Kate Robertson
Assistant Coroner for North Wales (East and Central)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** The Cabinet Secretary for Health and Social Care, Welsh Government
1	**CORONER** I am Kate Robertson, Assistant Coroner for North Wales (East and Central)
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 6 August 2024 an investigation was commenced into the death of Jeanette Sidlow Beech (DOB 8/7/1981) who died on 3 August 2024. The investigation concluded at the end of the inquest on 28 May 2025. The conclusion of the inquest was a narrative conclusion:- Jeanette Sidlow Beech died on 3 August 2024 at her home address from an alcohol withdrawal related seizure likely related to previous prolonged excessive alcohol use following a wait of 15 hours and 13 minutes for an ambulance
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are as follows :- Jeanette Sidlow Beech had a history of alcohol withdrawal related seizures. On 2 August 2024, whilst at her home address, she began to feel unwell. Her husband contacted the Welsh Ambulance Service Trust (WAST) at 12.52 hours. The call was categorised as Green 3 response with an estimated time of arrival given as 2 hours. A second call was made at15:16 hours indicating increased pain and vomiting with an impending seizure and had been upgraded to an Amber 2 category after clinical review. A third call was made at 03:51 hours when Jeanette was struggling to breathe, her body was seizing up and she was vomiting. The call was generated as red. A resource arrived at 04:05 hours. CPR was continued. Jeanette was confirmed as having passed away at 04:50 hours.

5	**CORONER'S CONCERNS** During the course of the inquest, the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows – a. It took a total period of 15 hours and 13 minutes for an ambulance to attend upon Jeanette, by which time she was in cardiac arrest and rescucitation efforts were unsuccessful. b. Whilst evidence was received and heard during the Inquest that efforts have been and are still being taken by WAST to improve the situation regarding ambulance delays, there remains significant concerns with Hospital handover delays. c. It is well known, having heard evidence in previous Inquests, that the causes of ambulance delays are multifactorial. They do not rest solely with WAST. d. Many Coroners in Wales have issued many Reports over many years on the time it takes for ambulances to attend on the background of various reasons. e. It appears to remain the case that the lack of social care provision and/or Community Hospitals means that those fit to be discharged from district general hospitals are not discharged and those in Emergency Departments or on ambulances outside Emergency Departments are unable to be provided with a bed in the hospitals such that ambulances remain outside Emergency Departments for hours. Evidence was heard that between 2nd and 3rd August 2024 at Betsi Cadwaladr University Local Health Board the longest delays in ambulance handover times were in excess of 6 hours and 7 hours. f. The issues identified are pertinent to WAST, the Health Board and Local Authorities. g. There appears to be no improvement in these ongoing issues and I am particularly concerned that lives are being put at risk, and that deaths will occur into the future and will continue to occur where this situation persists.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely 24 July 2025. I, Kate Robertson, the Coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Family of the deceased, the Chief Executive of the Welsh Ambulance Service Trust, the Chief Executive of Betsi Cadwaladr University Local Health Board, the Chief Executives of the local authorities within this jurisdiction, and to the Chief Coroner. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	Dated 29 May 2025  Signature Assistant Coroner for North Wales (East and Central)