GRAEME HUGHES

HIS MAJESTY'S SENIOR CORONER

SOUTH WALES CENTRAL CORONER AREA

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ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The First Minister of Wales**
1	**CORONER** I am Graeme D Hughes, H M Senior Coroner for the area of South Wales 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 20 March 2022 I commenced an investigation into the death of Valerie HILL . The investigation concluded at the end of the inquest 29/05/2025. The conclusion of the inquest was a Narrative. **1a Pnuemonia** **1b Fall leading to periprosthetic fracture of femur** **1c** **II Chronic obstructive pulmonary disease (COPD), frailty of old age**
4	**CIRCUMSTANCES OF THE DEATH**

	Valerie died by pneumonia and a fall leading to a periprosthetic fracture of femur. COPD and frailty of old age were contributing factors. Valerie died on 11 March 2022 at Royal Glamorgan Hospital, following a fall at Ty Bargoed Care Home on 7 March 2022. She endured a long lie on the floor of over 14 hours whilst waiting for an ambulance to attend. It is possible that this long lie exacerbated known medical conditions. It is probable that the lack of risk assessments completed and referrals for Valerie during her time at Ty Bargoed meant appropriate precautions were not taken to prevent further falls. It is possible, due to long ambulance handover times across Cwm Taf Morgannwg Health Board and inadequate systems in place to effectively manage patient flow that this contributed to the long lie.
5	**<u>CORONER'S CONCERNS</u>** 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. (1) On 17.2.22 you wrote (then as Minister for Health & Social Care) to the Chairs of all Health Boards in Wales, and *inter alia*, alerted the same to the following: - "The volumes of people waiting excessive periods for transfer from ambulance vehicles to the care of staff in Emergency Departments, in particular, has reached intolerable levels….I am concerned about the level of tolerance to such delays a require you to take greater ownership of this issue as a priority….the current situation cannot continue" The then, and continuing NHS Deputy Chief Executive [redacted] gave evidence at the Inquest. He indicated that CTMUHB had been in Targeted Intervention since October 2022 (2.5 years) and he hadn't seen significant improvement in relation to 15 minute or 1hr handovers. In answer to my final question to him as to whether a situation akin to that which Valerie faced on 7 March 2022 could happen again today, he accepted that that was a fair conclusion and that the same risks remain in the system In the the three years since Valerie's death you have received multiple Prevention of Future Death Reports from myself and fellow Coroner's in Wales highlighting the devastating outcomes attributable to delays in conveying acutely unwell patients to hospital/ambulance handover delays. Those risks continue and are of acute concern to myself and my Coronial colleagues throughout Wales. (2) Despite some relaxation in the guidelines set by the Welsh Ministers in relation to ambulance handover delays/timings in 2024, WAST continues to adopt the 15 minute handover expectation/assumption for their rostering. Yet I received evidence that hospitals

	across Wales are only delivering this expectation around 10-20% of the time. My concern is that this disconnect is having a significant effect upon how the system for conveying acutely ill patients in the community to hospital is operating and changes are indicated to address this system dysfunctionality. (3) On 17.2.22 [redacted], Chief Executive of NHS Wales wrote to you as then Minister for Health and Social Services & in relation to the then acute concerns she had over delayed ambulance handovers indicated as follows:- "A health and social care system leadership response is required to current operational pressures on a par to the Covid-19 response" [redacted] in his oral evidence confirmed that the response had not been on a par with the Covid-19 response My concern is that the prevalence and extent of such delays has become beyond intolerable and is leading to many acutely unwell patients in the community waiting for such prolonged periods for emergency care, dying directly & indirectly as a consequence. The balance of risk in the system appears to be borne disproportionately by the patients in that category & consideration ought to be given to redressing the same. (4) In your response to my Prevention of Future Death Report in relation to Lynda Blackmore (PFD and your response annexed) you indicated *inter alia*:- "For the past two iterations of the framework, I have been explicitly clear of my expectation that Health Boards prioritise plans to improve timeliness of ambulance patient handover to free up ambulance clinicians to respond to patients in the community…I have also set a priority for improvement of patient flow." My concern is that the same has not led to any discernible improvement in ambulance handover delays & that consideration might be given for a review of the level of escalation that not only applies on this issue to CTMUHB but also those Health Boards across Wales. I was repeatedly referenced at the Inquest by CTMUHB that their performance in many areas relating to ambulance handover times was not "the worst in Wales".
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 by 9th August. Only I, 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 all Interested Persons who may find it useful or of interest. Also to Health Inspectorate Wales and to each and every Senedd member as I consider the concerns I have raised and the matters investigated at Inquest of such potential significance to all of their constituents. 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	13 June 2025 **SIGNED:**  for South Wales Central Coroner Area