Regulations 28 and 29 of the Coroners' (Investigations) Regulations 2013

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: <u>The Chief Executive of Aneurin Bevan University Health Board</u>
1	**CORONER** I am **Caroline Saunders,** Senior Coroner for the Area of Gwent
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 18/11/2024 an investigation was opened touching upon the death of **Robyn Anne Chambers** The investigation concluded at the end of the inquest on 11/7/2025 <u>The conclusion of the inquest was recorded as</u> Natural Causes <u>The medical cause of death was:</u> 1a) Lower Respiratory Tract Infection 1b) Chronic Lung Disease 1c) Extreme Prematurity. Hypoxic Ischaemic Encephalopathy. Epilepsy and Global Developmental delay. 2. Previous Duodenal Perforation.
4	**CIRCUMSTANCES OF THE DEATH** Robyn Anne Chambers sustained hypoxic ischaemic encephalopathy when she was born prematurely at 23 weeks gestation. This led to significant physical and neurological problems, including ongoing respiratory problems. On 26/10/2024, Robyn developed a chest infection. Despite intensive treatment, the effects were overwhelming and resulted in Robyn's death on 2/11/2024 at Ty Hafan Hospice in Sully.

5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows: - Following Robyn's traumatic birth she was cared for at home by her parents. Robyn needed extensive medical intervention and monitoring at home. When she became unwell on 26/10/2024 her parents called an ambulance and were informed that it would take about 8 hours for an Amber 1 ambulance to respond. Robyn's parents decided to take Robyn to hospital themselves which was a difficult and potentially dangerous journey because Robyn had complicated medical equipment that needed to remain attached. The estimated length of time for an ambulance to be dispatched and the decision taken by Robyn's parents to convey her to hospital had no impact on Robyn's care and did not affect the outcome. However, having heard evidence from Welsh Ambulance Service NHS Trust, I note that the main reason for the delay in dispatching emergency ambulances remains the length of time it is taking for ambulances to be released from the emergency department of Aneurin Bevan University Health Board hospitals, predominantly the Grange University Hospital. Evidence provided at inquest indicated that, at the time that Robyn's parents called for an ambulance, the longest time an ambulance was delayed at the GUH was in excess of 10 hours.
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. I am concerned that despite previous assurances that action was being taken by ABUHB and WAST in relation to managing ambulance delays (which I appreciate can be multi-factorial) a significant problem remains in relation to the release of ambulances from the GUH Emergency Department. The handover times are far exceeding the 15-minute handover time agreed between these 2 organisations. Patients' lives are being, and will continue to be, put at risk if this situation is not resolved.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely 16 September 2025. I, the Coroner, may extend this 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 necessary
8	**COPIES AND PUBLICATION** I have sent a copy of my report to the Chief Coroner and the following Interested Person (s)

	• The family of Robyn Chambers 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 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	**DATE 22/7/25** Signed  Caroline Saunders **His Majesty's Senior Coroner for Gwent.**