**John Adrian Gittins**
**Senior Coroner for North Wales (East and Central)**

| | |
|---|---|
| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO: Welsh Ambulance Services University NHS Trust**<br>Ty Elwy, Unit 7 Ffordd Richard Davies, St Asaph Business Park, St Asaph, Denbighshire LL15 2NG |
| 1 | **CORONER**<br><br>I am John Adrian Gittins, Senior Coroner for North Wales (East and Central) |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On the 9th of April 2025, I commenced an investigation into the death of Heather Louise Parkhill (DOB 8.8.85 DOD 8.4.25). The investigation concluded at the end of the inquest on the 29th of January 2026. The cause of death was recorded as being due to 1(a) Fatty Liver Disease and the conclusion of the inquest was as follows:<br><br>Narrative Conclusion : Heather Parkhill was verified dead at her home on the morning of the 8th of April 2025, more than fifteen hours after an initial 999 call was made to seek assistance for her. Her death was the result of a terminal event arising from a condition associated with the chronic excessive consumption of alcohol, but it is probable that the death would have been prevented by earlier medical intervention, although none was available. The deceased's death was ultimately alcohol related but contributed to by neglect. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>The circumstances of the death are that at 20.41 on the 7th of April 2025 a 999 call was made seeking the assistance of the ambulance service to Mrs Parkhill, however there were no resources available for deployment at that time. A screening review was conducted at 21.27 which resulted in the erroneous downgrading of the priority of the call. Further calls were made seeking help on the morning of the 8th of April at 06.49, 07.04, 07.39, 08.33 and 09.37 however due to resource issues, no ambulance was able to attend during this period.<br><br>At 10.41 a final call resulted in the highest category priority and the first responder was on scene seven minutes later. Resuscitation efforts were discontinued around one hour later, more than fifteen hours after the first call for assistance.<br><br>Evidence was given to the inquest indicating that an earlier response (even 20-30 minutes earlier) would probably have prevented this death. |

| | |
|---|---|
| 5 | **CORONER'S CONCERNS**<br><br>Category of Concern – Emergency Services Related Death<br><br>During the course of the inquest the evidence revealed the following matter 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.<br><br>The **MATTER OF CONCERN** is as follows. –<br><br>For many years, myself and other coroners have raised concerns regarding so called "ambulance delays" and I recognise that the challenges faced by WAST around the availability of resources are the result of multifactorial issues, however problems regarding the unavailability of resources persist. I have a mandatory statutory responsibility to raise concerns where they exist and it is clear that lives continue to be lost as a result of this problem.<br><br>Despite all of the multi-agency efforts to improve the availability of resources and hence response times, nothing appears to change I therefore remain concerned that lives continue to be at risk |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 30th of March 2026 I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Family of the Deceased and to the Chief Coroner.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 2nd of February 2026<br><br>Signature [redacted]<br>Senior Coroner for North Wales (East and Central) |