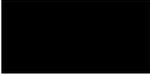




Kate Robertson
Assistant Coroner for North Wales (East and Central)

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO: [REDACTED], Cabinet Secretary for Health and Social Care</p>
1	<p>CORONER</p> <p>I am Kate Robertson, Assistant Coroner for North Wales (East and Central)</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 13 June 2025 an investigation was commenced into the death of Angela Frances Darlow (DOB 19 April 1952) who died on 7 June 2025. The investigation concluded at the end of the inquest on 5th February 2026. The conclusion of the inquest was a narrative conclusion that death was due to natural causes contributed to by opportunities for medical investigations and potential treatment lost due to the time it took for the ambulance to arrive and convey her to hospital where such investigations may have afforded her treatment for the condition from which she died</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>The circumstances of the death are as follows :-</p> <p>Angela Darlow had a stroke at home on 6 January 2025. An Ambulance was immediately called. This arrived after 23 hours and 20 minutes. She was conveyed to the Countess of Chester Hospital arriving 1 hour and 7 minutes later. She was diagnosed with an extensive left middle cerebral artery infarct. Given the passage of time she was not suitable for investigations and thrombectomy. She instead received antiplatelets and was admitted to the stroke ward. She remained stable and was transferred to Mold Community Hospital on 7 March 2025 with a poor prognosis. She died from the effects of the stroke at hospital on 7 June 2025.</p>

5	<p><u>CORONER'S CONCERNS</u></p> <p>Category of Concern – Emergency Services Related Death; Ambulance Delays (resources)</p> <p>During the course of the inquest, the evidence revealed matters giving rise to concern.</p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <p>Angela Darlow was suffering from symptoms of a stroke at home during the afternoon of 6 January 2025. Her husband immediately contacted the Welsh Ambulance Service via 999. Given the significant demand at this time, it took 23 hours and 20 minutes for an emergency ambulance to attend. The calls made to the Trust were correctly categorised. By the time Angela arrived at the nearest hospital, The Countess of Chester, she was outside the time for investigations for thrombectomy.</p> <p>At the time in question demand was unprecedented. This is reflected by the 23 hour and 20 minute delay in ambulance arriving.</p> <p>There were significant hospital handover delays at the time which added to the demand on the Trust.</p> <p>The facts in Angela’s death speak for themselves. I continue to remain concerned about the time is it taking for ambulances to arrive in the context of the multifactorial reasons for this which include patient flow in hospitals and limited social care provision. People are dying due to these issues and yet we are no closer to improvement.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely 2 April 2026. I, Kate Robertson, the Coroner, may extend the period.</p> <p>I would be prepared to accept a joint response from all organisations.</p> <p>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.</p>

8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Family of the Deceased and to the Chief Coroner. I have also sent a copy of this Report to Chief Executive of Betsi Cadwaladr University Local Health Board and to the Chief Executive of the Welsh Ambulance Service Trust.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>Dated 5 February 2026</p> <p></p> <p>Signature Assistant Coroner for North Wales (East and Central)</p>