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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Chief Executive, Welsh Ambulance Services NHS Trust, HM Stanley Site, St Asaph, Denbighshire LL17 0RS, BCUHB, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd LL57 2PW
1	**CORONER** I am JOHN ADRIAN GITTINS, senior coroner, for the coroner area of 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 the 18th of March 2016 I commenced an investigation into the death of Rebecca Anne Evans (DOB 18.2.60, DOD 15.3.2016). The investigation concluded at the end of the inquest on the 6th of March 2017 and I recorded a conclusion of death arising from natural causes.
4	**CIRCUMSTANCES OF THE DEATH** On the 9th of March 2016 the Deceased was taken to Glan Clwyd Hospital from her care home due to her declining medical condition as a result of a chest infection against a background of Huntington's Disease. Due to multifactorial problems at the hospital she waited for more than seven hours in the ambulance outside the Emergency Department before being admitted and thereafter despite appropriate treatment she continued to decline and passed away a few days later.
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 :- 1. That there were significant delays in the admission of Ms Evans to Hospital and that medical treatment was consequently not commenced in a timely manner. 2. That despite changes having been made previously the current practices in place for the handover of patients at an Emergency Department far too often results in wholly unacceptable delays with patients being kept waiting for long periods in ambulances and ambulance resources consequently being unavailable for allocation to other calls. Whilst this is a multi-factorial problem, improvements must be made so as to reduce the risk of future deaths.

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	3. It is of grave concern to me that my statutory duty requires me to report these concerns by way of regulation 28 reports on a very regular basis and that despite previous such reports there continue to be substantial delays in the handover of patients particularly as a result of problems in patient flow resulting in an inability to admit patients who require treatment.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisations 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 May 2017 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 the Chief Coroner and to the following Interested Person – The Family of the Deceased 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 14th March 2017 Signature_____ Senior Coroner for North Wales (East and Central)

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