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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** BCUHB, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd LL57 2PW, Denbighshire County Council, County Hall, Wynnstay Road, Ruthin LL15 1YN, Conwy County Council Bodlondeb, Bangor Road, Conwy, Wrexham County Borough Council The Guildhall, Wrexham, Flintshire County Council County Hall, Mold, Welsh Ambulance Services NHS Trust, HM Stanley Site, St Asaph, Denbighshire LL17 0RS, National Assembly for Wales Cardiff Bay, Cardiff CF99 1NA
1	**CORONER** I am John Adrian Gittins, Senior Coroner for 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 8th of September 2014 I commenced an investigation into the death of Lilly Baxandall (DOB 22.9.1918 DOD 5.9.2014) The investigation concluded at the end of the inquest on 9th of May 2017. The conclusion of the inquest was one of an accidental death the Cause of Death being recorded as 1(a) Subdural Haematoma, Pneumonia (b) Head Injury
4	**CIRCUMSTANCES OF THE DEATH** On the 1st of September 2014 the Deceased was found collapsed at her home after an unwitnessed fall. She had suffered a head injury as a result of the fall and an ambulance was called to her assistance. The ambulance arrived at Glan Clwyd Hospital at 17.21 hours however it was not possible for her handover to be completed within the agreed turnaround time of 15 minutes due to capacity issues within the hospital resulting in there being a large number of ambulances queueing outside and thus also depleting available resources for response to new calls. By 20.22 hours her condition had deteriorated significantly and although she had been seen by hospital staff whilst in the back of the ambulance her handover did not take place until 21.14 almost four hours after her arrival. A CT scan was undertaken at 22.25 which revealed a large acute subdural haematoma which could not be treated and she passed away on the morning of the 5th of September.
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. – Following an inquest which concluded in January 2014 I issued a regulation 28 report in which I expressed concerns regarding the handover of patients at an emergency department which resulted in "unacceptable delays with patients being kept waiting for long periods in ambulances and ambulance resources consequently being unavailable for allocation to other calls".

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	In September 2014 I issued a further regulation 28 report raising similar concerns regarding delays. In November 2015 I issued a regulation 28 report concerning delays in an emergency department which "were excessive and inadequate action was taken by the Health Board to overcome the problems of staff shortages leading to long waiting times and risks to patients". In December 2015 I issued a regulation 28 report expressing concerns regarding the throughput of patients in hospital and Delayed Transfer of Care. In August 2016 I issued a regulation 28 report regarding a delay in admission to hospital via the emergency department which formed part of a cumulative delay in diagnosis and treatment which prevented a patient having the best prospect of a successful outcome. In January 2017 I issued a regulation 28 report expressing a concern "that there are invariably delays in admissions to hospital as there are insufficient beds available to accommodate all admissions." In March 2017 I issued a regulation 28 report expressing concern that 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" Despite the above reports issued to the Health Board and Ambulance Service the problems of ambulance delays/handover delays/bed blocking/patient flow and delayed transfer of care continue to the present day and patients' lives are being placed at risk as a result. It is very well recognised that the issues are multifactorial and will require multi agency cooperation for improvements or change to be made, however unless services and resources are made available or working practices altered to facilitate such change then it is inevitable that future deaths will occur which might have otherwise been preventable.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 12th July 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 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 17th May 2017 Signature_____ Senior Coroner for North Wales (East and Central)

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