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,
1	**CORONER** I am Nicola Jones Assistant 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 15th of February 2016 I commenced an investigation into the death of Catherine Haf Roberts (DOB 26 May 1933 DOD 11 February 2016) The investigation concluded at the end of the inquest on the 5th of February 2017. The conclusion of the inquest was one of Natural Causes, the Cause of Death being recorded as 1(a) Acute Gastroenteritis
4	**CIRCUMSTANCES OF THE DEATH** Mrs Roberts arrived at Ysbyty Glan Clwyd by ambulance at 01.26 hours on 6 February 2016 after becoming unwell at home with persistent diarrhoea. She waited in an ambulance outside hospital until 03.25 hours due to the emergency department being full to capacity and Mrs Roberts requiring a cubicle. As there was no space within the hospital on a medical ward Mrs Roberts remained in the emergency department for 58 hours before being transferred to a medical ward where her condition deteriorated. Mrs Roberts died in hospital on 11 February 2016.
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. – The issues of admission to the Emergency Department/availability of resources/patient flow and the multifactorial problems associated with cases of this nature have been reported upon by the Senior Coroner on several occasions following previous inquests. Despite the above reports issued to the Health Board these problems continue to the present day and patients' lives are being placed at risk as a result. Whilst I am aware that all necessary parties are working towards a system plan to address these issues and that elements of that plan have been agreed, there remains no agreed and effective system plan in place.
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.

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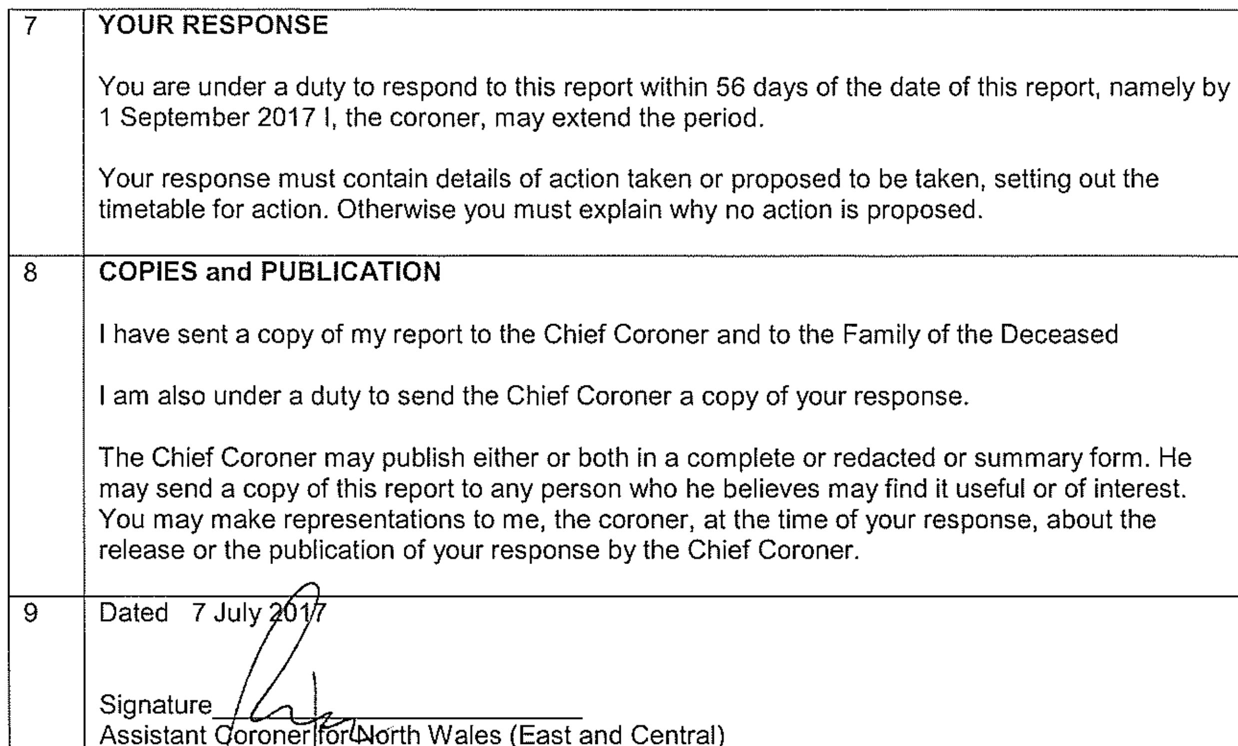

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 1 September 2017 I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you 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 7 July 2017 Signature____________________ Assistant Coroner for North Wales (East and Central)

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