Mr David Pojur
Assistant Coroner
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, Welsh Ambulance Services NHS Trust, HM Stanley Site, St Asaph, Denbighshire LL17 0RS,
1	**CORONER** I am David Pojur, 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 18th April 2017 this Court commenced an investigation into the death of Ester Jane Wood (DOB.8.70 DOD 6.4.17) The investigation concluded at the end of the inquest on the 6th June 2018. The conclusion of the inquest was one of Natural Causes the Cause of Death being recorded as 1(a) Bronchopneumonia, Left Ventricular and Liver Failure (b) Myocardial Infarction Alcoholic Liver Disease (c) Recurrent Pancreatic Neuroendocrine Tumour
4	**CIRCUMSTANCES OF THE DEATH** Ester Wood was taken from her home address to the Maelor Hospital via ambulance on 03.04.07 and waited from 20.05hrs until 1am in the ambulance where she was stable. On admission and subsequent examination she was in a very poor clinical condition. Despite best efforts several organs were failing and she did not respond to medical interventions. The position was futile.
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 ambulance delays/admission to ED/availability of resources/patient flow and the multifactorial problems associated with cases of this nature have been reported upon by this Court on several occasions following previous inquests, most recently on 17th May 2017 by Mr Gittins, Senior Coroner concerning the death of Lilly Baxendall. Despite the above reports issued to the Health Board and other relevant bodies these problems continue to the present day and patients' lives are being placed at risk as a result.

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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 1st August 2018 I, the Coroner or the Senior 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 6th June 2018 Signature_____ **David Pojur** **Assistant Coroner** **North Wales (East and Central)**

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