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, Welsh Ambulance Services NHS Trust, HM Stanley Site, St Asaph, Denbighshire LL17 0RS,
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 6th of February 2018 I commenced an investigation into the death of Margaret Megan Evans (DOB 28.12.24 DOD 5.2.18) The investigation concluded at the end of the inquest on the 22nd of June 2018. The conclusion of the inquest was one of an accidental death the Cause of Death being recorded as 1(a) Hospital Acquired Pneumonia 2. Fractured Neck of Femur
4	**CIRCUMSTANCES OF THE DEATH** On the 22nd of January 2018 the Deceased fell outside her home and sustained a fractured hip as a result. An ambulance was summonsed to assist her at 10.32 however no ambulances were available and an ambulance did not arrive until 13.51. Thereafter the left the scene at 14.25 arriving at the Emergency Department of the Maelor Hospital, Wrexham at 14.51. Due to the department being busy she was not brought in until 21.22 and was seen by the consultant at 21.28. As a consequence of the above the Deceased had to endure more than three hours lying on a concrete path and was not seen by the ED doctor until almost eleven hours after help was initially summonsed although it cannot be said that these delays contributed to her death.
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 me on numerous occasions following previous inquests. Despite the above reports issued to the Health Board and Ambulance Service 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 21st August 2018 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. 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 26th June 2018 Signature_____ Senior Coroner for North Wales (East and Central)

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