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 and 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 11th of April 2018 I commenced an investigation into the death of Madeline Constance Staples (DOB 19.7.31 DOD 9.4.2018) The investigation concluded at the end of the inquest on 7th of February 2019. The conclusion of the inquest was one of an accidental death the Cause of Death being recorded as 1(a) Bronchopneumonia (b) Immobilisation due to Femoral and Tibial Fractures 2. Lung Cancer
4	CIRCUMSTANCES OF THE DEATH On the 6th of April 2018 the Deceased (an 86 year old lady) had an unwitnessed fall in her care home. She had sustained long bone fractures of both legs as a result of the fall and the position in which she was lying prohibited her from receiving oral pain relief. An ambulance was called to her assistance at 22.11 hours however due to the absence of available resources (primarily due to lost ambulance hours awaiting discharge of patients at hospital) it was not possible to get assistance to her (and hence some pain relief) until 03.40 hours during which time she remained according to the attending paramedic, "crying out in pain which could be heard from the entrance of the care home despite her room being on the second floor". A second ambulance was required to assist in her removal to hospital and again there was a delay in this being allocated due to an absence of available resources and she did not reach hospital until 05.23 around seven and a quarter hours after the first call for help. Despite treatment for her injuries her condition deteriorated and she died on the 9th of April 2019 at 23.20.
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 the intervening period from then until the present either I or my Assistant Coroners have issued at least a further twelve similar regulation 28 reports expressing concerns associated with unacceptable delays and yet despite being given assurances in the responses to the same by BCUHB and WAST (and other organisations) that action is being taken to reduce such delays, the situation continues to prevail. As has been stated previously in my other reports, I recognise that the issues which cause these difficulties is multifactorial, however unless services and resources are made available or working practices altered to facilitate change then it is inevitable that future deaths will occur which might have otherwise been preventable. Patients' lives are being placed at risk and this is wholly unacceptable.
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 8th April 2019. 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 11th February 2019 Signature_____ Senior Coroner for North Wales (East and Central)

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