REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Welsh Ambulance NHS Trust** **Betsi Cadwaladr University Local Health Board**
1	**CORONER** I am Kate Sutherland, Assistant Coroner, for North Wales (East & 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 4.11.22, an investigation was commenced into the death of Raymond Gillespie. The investigation concluded at the end of an Inquest on 24 May 2022. The conclusion of the inquest was :- Natural causes contributed to by a fall The medical cause of death was 1a. frailty of old age, dementia, chronic kidney disease 2. Acute on chronic kidney disease, fractured neck of right femur (non-operated)
4	**CIRCUMSTANCES OF THE DEATH** These were recorded as :- Raymond Gillespie was a care home resident suffering from a number of comorbidities. On 8 October 2021 he suffered an unwitnessed fall. Welsh Ambulance Service Trust (WAST) were contacted at 21.59 due to hip pain and potential fracture. An initial response of 6 hours was provided for response (health care professional category, extended from 4 due to resource issues). Several welfare checks were conducted throughout the night by WAST. The following day at 11.40 a further 999 call was made by the care home as there was still no WAST attendance. At 12.57 a paramedic arrived, some 14 hours and 58 minutes following the initial call.
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. –

	(1) The first cause of the delay given was that all available resources were managing incidents of a higher acuity or same category but registered prior to this call (2) The second cause of the delay was a handover delay across all BCUHB sites. A total of 131.1 hours were lost in delay of handovers on 9 October 2021. (3) Whilst on the evidence it was not found that the delay contributed to Mr Gillespie's death there remains a significant risk that deaths will continue to occur or that future deaths will occur either with patients waiting to be transferred into hospital from the ambulance or by ambulances not being available to those in the community requiring paramedic assistance and transfer to hospital. (4) The matters of concern herein are longstanding and despite proposed future action the concerns remain.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 20 July 2022 Only, 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 deceased's family and the Health Inspectorate Wales who may find it useful or of interest. 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	25 May 2022 **SIGNED:**  Kate Sutherland, Assistant Coroner for North Wales (East & Central)