REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	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 JOHN ADRIAN GITTINS, senior coroner, for the coroner area of 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 of March 2013 I commenced an investigation into the death of Esther Jane Jones (DOB 30.08.1919 DOD 30.03.2013). The investigation concluded at the end of the inquest on the 18th of June 2014 and I recorded a conclusion of Natural Causes with the cause of death being 1(a) Pulmonary Embolus due to 1(b) Phlebothrombosis (Right Leg)
4	**CIRCUMSTANCES OF THE DEATH** The Circumstances of the death are that the Deceased had died at the Maelor Hospital, Wrexham and although it was established that the death was ultimately due to Natural Causes there had been a Serious Incident Review conducted by BCUHB following the death as a result of concerns arising in relation to missed medication.
5	**CORONER'S CONCERNS** During the course of the inquest, evidence given by the family of the Deceased and by representatives of BCUHB established that there had been a substantial delay in the completion of the SIR and the sharing of this with myself as Coroner and with the family of the Deceased. I am concerned that in cases where Serious Incident Reviews are taken, any delay in the completion of the same could pose a risk to other patients as lessons learnt from the same may not be disseminated to staff in a timely manner and further that the conclusion of my own investigations may be also be delayed, potentially limiting the effectiveness of a Regulation 28 report. The **MATTERS OF CONCERN** are as follows :- That unless steps are taken to improve the process by which SIRs are conducted and completed, then this could pose continuing risks to others and may lead to future deaths.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 27th August 2014 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 following Interested Person – [redacted] (Daughter 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	**[DATE] 2nd July 2014 [SIGNED BY CORONER]**