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 7th of June 2012 I commenced an investigation into the death of Sally Ellison (DOB 3.8.57, DOD 1.6.12). The investigation concluded at the end of the inquest on the 24th of April 2015 and I recorded a conclusion of an Accidental death
4	**CIRCUMSTANCES OF THE DEATH** The Circumstances of the death are that Mrs Ellison contracted the legionella infection whilst on holiday in Tunisia in Mid-May 2012 and her death on the 1st of June 2012 was due to 1(a) Cardiac Arrest (b) Multi Organ Failure (c) Legionella Pneumonia
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. That although it was clear upon her admission to Glan Clwyd on the 29th of May 2012 at around 16.00 hours, that she was suffering from a severe form of Community Acquired Pneumonia, and that this was recognised as being an atypical pneumonia that same evening, no urine sample was sent for analysis until overnight on the 31st of May with the confirmation of it being positive for legionella coming on the morning of the 1st of June. It is the case that treatment was already being given for the possibility of legionella from the 30th of May, but this was not against a confirmed diagnosis and therefore optimal treatment may have been delayed.

	2. Not only should consideration therefore be given to undertaking tests at an earlier stage but there should also be available to the hospital a rapid testing and reporting service, either preferably a service within North Wales or utilising options within organisations geographically closer and more accessible than those in Cardiff.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisations 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 22nd June 2015 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](Husband 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] 27th April 2015 [SIGNED BY CORONER]** [redacted]