D. Pritchard Jones
Senior Coroner for North West Wales

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Medical Director, Glan Clwyd Hospital, Rhuddlan Road, Bodelwyddan, Denbighshire. LL18 5UJ**
1	**CORONER** I am D. Pritchard Jones, Senior Coroner for North West Wales
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 31/12/2014 I commenced an investigation into the death of Barry Wilson, aged 70 years . The investigation concluded at the end of the inquest on 22 April 2015. The conclusion of the inquest was that Death was due to misadventure. Mr. Wilson had been admitted to Glan Clwyd Hospital on the 19th December with abdominal pain and a CT scan confirmed bowel obstruction. He was operated on 20th December and on 24th December he was discharged from hospital. On discharge he was in severe pain on mobilising and collapsed at his home. He was taken to Ysbyty Gwynedd, Bangor on 25th December 2014 where life was pronounced extinct at 16.07 hours.
4	**CIRCUMSTANCES OF THE DEATH** COD: (1a) Peritonitis (1b) Anastamotic breakdown (1c) Right hemicolectomy
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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) It would appear from the evidence that the deceased had undergone a right hemicolectomy and that the anastomosis had been made with staples. The anastomosis was defective and this should have been apparent either on or prior to the deceased's discharge from hospital. If the defect had been detected at that stage Mr. Wilson might not have died.

37 Castle Square, Caernarfon, Gwynedd, LL55 2NN
Tel 01286 672804 | Fax 01286 675217

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you Medical Director, Glan Clwyd Hospital 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 26 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 Persons [redacted] 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	Dated 29 April 2015 Signature_____ D. Pritchard Jones Senior Coroner for North West Wales

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