REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **CHIEF EXECUTIVE BETSI CADWALADR UNIVERSITY NHS TRUST**
1	**CORONER** I am Nicola Jones, assistant coroner, for the coroner area of North East and North Central 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.
3	**INVESTIGATION and INQUEST** On 3 November 2014 I commenced an investigation into the death of Vera Hilda Williams , aged 77. The investigation concluded at the end of the inquest on 18 September 2015. The conclusion of the inquest was – Medical Cause of death: - 1a. Massive Gastrointestinal Tract Haemorrhage due to 1b. Oesophageal- Aortic Fistula due to 1c. Oesophageal Rupture. Conclusion : Death was due to an accident.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Williams attended the Emergency Department of Glan Clwyd Hospital on 10 October 2014 complaining of pain after eating toast. She was given pain killers and observed to be swallowing. Mrs Williams was examined . Upon a review the pain had been resolved and she was sent home. The Emergency Department doctor took the view that there had been an obstruction which had resolved itself. Mrs Williams returned to the Emergency Department on 23 October 2014 complaining of pain in the left side of her face and back of her neck. Usual Observations and bloods taken. Her chest was examined but not x rayed. Mrs Williams was discharged home at 02.20 hours with oral antibiotics and painkillers. She was suspected of having a mild upper respiratory tract or urinary infection. Mrs Williams attended the Emergency Department at 19.09 after calling an ambulance at 17.46 on 24 October 2015. She had coughed and vomited a blood clot. She was generally unwell. At 16.00 hours on 25 October 2015 after other investigations including Chest Xray, Bloods, General observations and physical examination , a CT scan revealed that Mrs Williams had a ruptured aorta . It is probable that this was caused by swallowing the toast which was complained of on her first visit to the emergency Department on 10 October 2104. Surgical intervention was not appropriate for Mrs Williams and she died on 28 October 2015 at Glan Clwyd Hospital. The presentation for Mrs Williams was different on the three separate occasions that she attended the Emergency Department. The Doctors on call had to rely upon Mrs Williams to tell them that she had been admitted previously and what had occurred on those previous visits to the Emergency Department. In this case it was only the CT Scan which showed the Oesophageal Rupture. The presentation of Mrs Williams on the 10th and 24 th October was not such that a CT Scan could reasonably be expected to be carried out on the examination and presentation of Mrs Williams on those occasions.

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) Doctors and staff in the Emergency Department do not have a DIGITAL CENTRAL RECORD (ie on a computer database) of who has passed through the Emergency Department , their symptoms and what treatment they have received. (2)Doctors must rely upon the patient telling them what has happened and then there is a delay whilst previous paper notes are located and retrieved. This lack of easy and swift access to accurate information is fraught with risks for patients and clinicians in the arena of Emergency medicine where time is of the essence in coming to a diagnosis. An accurate history is an essential tool in coming to that diagnosis. Any delay can have potentially fatal consequences for a patient.
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 8th January 2016. 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] daughters of Mrs Williams. 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]** **[SIGNED BY CORONER]** **6th November 2015** **Nicola Jones**