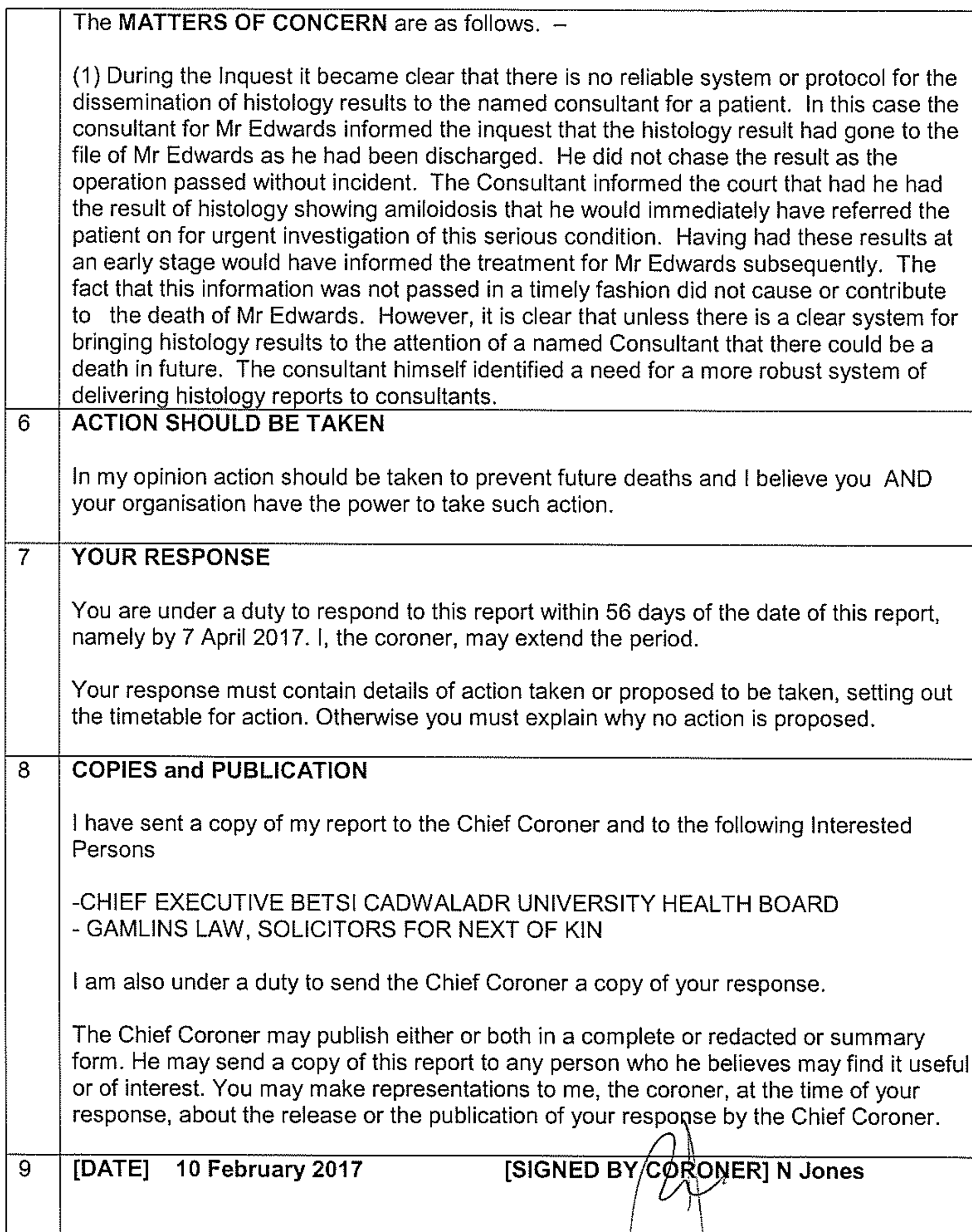
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **CHIEF EXECUTIVE BETSI CADWALADR UNIVERSITY HEALTH BOARD**
1	**CORONER** I am Nicola Jones, assistant coroner, for the coroner area of North Wales (Eastern 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 14 November 2016 I commenced an investigation into the death of Mr Raymond Edwards, aged 69. The investigation concluded at the end of the inquest on 23 January 2017. The conclusion of the inquest was: NARRATIVE CONCLUSION- On 24 November 2015 Mr Raymond Edwards was operated for Terminal Ileum. He developed an anastomatic leak which was operated on 1 December 2015 but Mr Edwards died from sepsis and multi organ failure on 2 December 2015 at Ysbyty Glan Clwyd.
4	**CIRCUMSTANCES OF THE DEATH** Mr Raymond Edwards was initially admitted to Glan Clwyd Hospital on 17 June 2015 and underwent a laparotomy for ischaemic bowel secondary to small bowel volvulus. He was discharged on 2 July 2015. Histology of the excised bowel was undertaken and revealed the rare disease amyloidosis. This histology result was never received by the named consultant and the disease was not followed up. Mr Edwards was re admitted to Glan Clwyd Hospital on 13 November 2015 after feeling generally unwell. On 24 November 2015 Mr Edwards was operated upon and his appendix removed and a small area of ischaemic bowel excised and a primary anastomosis. By the date of this operation the relevant department were aware of the amilioidosis. By 1 December 2015 Mr Edwards' condition rapidly deteriorated suggestive of an anastomotic leak. This was operated on 1 December2015 but Mr Edwards continued to deteriorate and died on 2 December 2015. The medical cause of death was 1a. Multi Organ Failure, Sepsis 1b. Anastomotic Leak (Operated 1 December 2015), 1c. Ischaemic Terminal Ileum (operated 24/11/2015). II. Pulmonary Embolism (warfarinised), Rheumatoid Arthritis (on Methotrexate), Laparotomy for Ischaemic Small Bowel secondary to small bowel volvulus (operated 17/06/2015), Amiloidosis.
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) During the Inquest it became clear that there is no reliable system or protocol for the dissemination of histology results to the named consultant for a patient. In this case the consultant for Mr Edwards informed the inquest that the histology result had gone to the file of Mr Edwards as he had been discharged. He did not chase the result as the operation passed without incident. The Consultant informed the court that had he had the result of histology showing amiloidosis that he would immediately have referred the patient on for urgent investigation of this serious condition. Having had these results at an early stage would have informed the treatment for Mr Edwards subsequently. The fact that this information was not passed in a timely fashion did not cause or contribute to the death of Mr Edwards. However, it is clear that unless there is a clear system for bringing histology results to the attention of a named Consultant that there could be a death in future. The consultant himself identified a need for a more robust system of delivering histology reports to consultants.
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 7 April 2017. 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 -CHIEF EXECUTIVE BETSI CADWALADR UNIVERSITY HEALTH BOARD - GAMLINS LAW, SOLICITORS FOR NEXT OF KIN 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] 10 February 2017 [SIGNED BY CORONER] N Jones**