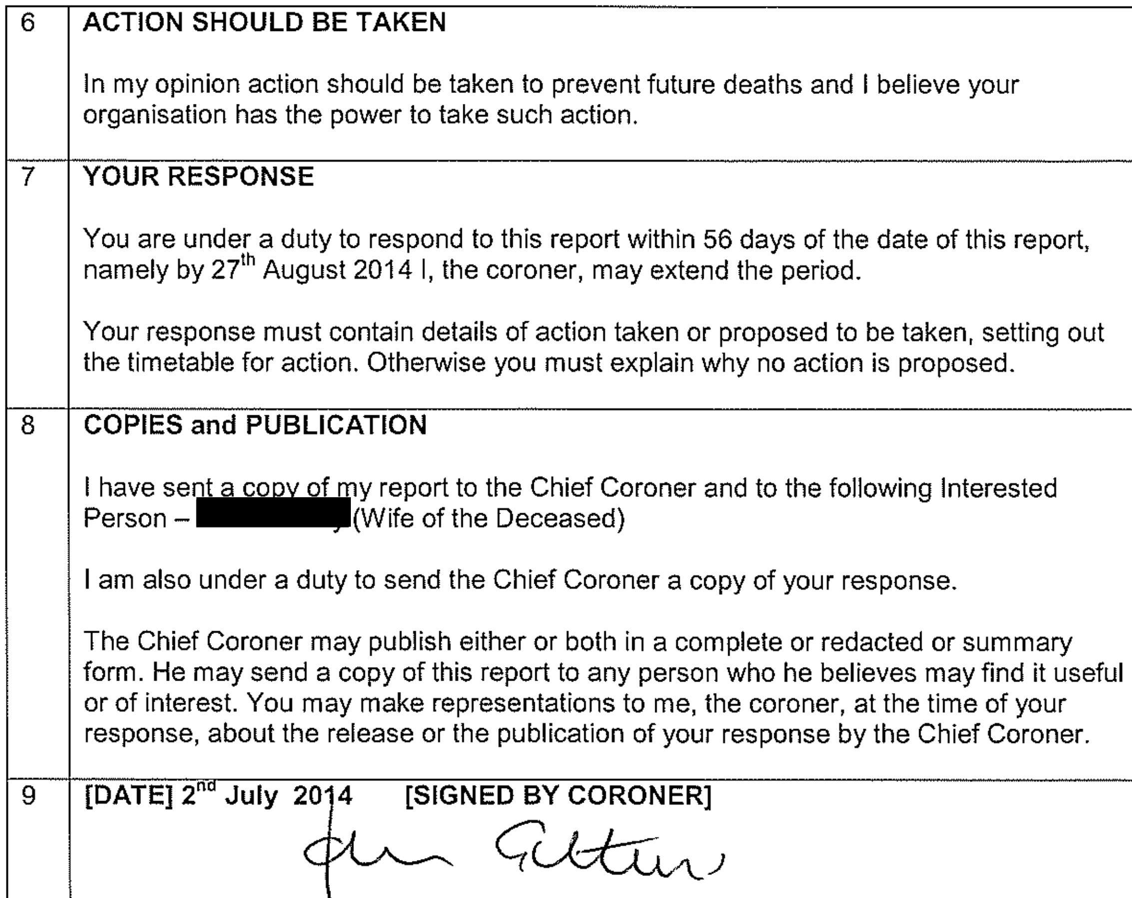
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	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 21st of January 2014 I commenced an investigation into the death of Ronald Perry (DOB 22.11.1955 DOD 18.01.2014). The investigation concluded at the end of the inquest on the 19th of June 2014 and I recorded a conclusion of Natural Causes with the cause of death being 1(a) Ruptured Atheromatous Aortic Aneurysm
4	**CIRCUMSTANCES OF THE DEATH** The Circumstances of the death are that the Deceased had attended at Glan Clwyd Hospital, Bodelwyddan on the 17th of January 2014 and that following examination at their Emergency Department was discharged home. Several hours later he collapsed, was readmitted but could not be resuscitated.
5	**CORONER'S CONCERNS** During the course of the inquest, evidence given by [redacted] indicated that had the Deceased undergone a CT scan then it is probable that his aneurysm would have been detected and that he would have undergone surgery. However different criteria exist within BCUHB by which CT scans can be requested by clinicians dependent upon the time of day (before or after 5.00 pm) or whether such a request is made at a weekend. The **MATTERS OF CONCERN** are as follows :- That unless steps are taken to provide consistency within the levels of care provided to patients on a 24 hour basis then there will be continuing risks to patients "out of hours" 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 – (Wife 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]**