REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **Governance Support Manager for the Pathology Clinical Programme Group, Glan Clwyd Hospital, Sarn Lane, Bodelwyddan.**
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 urgent blood tests were requested By [redacted] (GP) at lunchtime on the 28th of April 2012, yet despite these being noted as urgent, the samples were not conveyed to the laboratory for analysis after collection by the district nurse, until a routine collection of samples was undertaken from Colwyn Bay Community Hospital later that afternoon. As a result the delay in analysis meant that results were not provided to surgery until the following morning. Whilst the evidence indictates that changes have been made within the laboratory at Glan Clwyd to enable the immediate reporting of all cases where the CRP is greater than 300, there was no evidence available to confirm that all urgent tests could

	be expedited by district nurses thus alleviating potentially life threatening delays in treatment.
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]