REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive of Hywel Dda University Health Board Withybush General Hospital Fishguard Road Haverfordwest SA61 2PZ**
1	**CORONER** I am Jonathan Mark Layton senior coroner, for the coroner area of Carmarthenshire and Pembrokeshire.
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 2^{3rd} May 2014 I commenced an investigation into the death of Cerith Wyn Pugh then aged 62 who died on 20th May 2014. The investigation concluded at the end of the inquest on 27th July 2016. The conclusion of the inquest was a narrative one. The deceased had disordered liver function tests from January 2014 onwards. They remained disordered in March 2014. Despite this the deceased was not admitted as an inpatient following his treatment for an orthopaedic problem in March 2014 and no MRCP (magnetic resonance cholangio-pancreatography) procedure was carried out on him as an inpatient. An MRCP would have revealed the presence of gallstones blocking the deceased's bladder and common bile duct. This would have led to an invasive procesure to remove the gallstones. The medical cause of death was: Ia multi-organ failure b ischaemic bowel disease II cholelithiasis, mechanical jaundice
4	**CIRCUMSTANCES OF THE DEATH** (1) On 29th March 2013 Cerith Wyn Pugh underwent surgery for a bowel obstruction. (2) His recovery was slower than anticipated and on 18th April 2013 suffered a cardiac arrest and underwent further surgery. (3) A CT scan indicated the possible presence of a stone in the bile duct and an ERCP was undertaken. Mr Pugh was subsequently discharged from hospital. He remained in poor health and there were further readmissions. (4) Mr Pugh was readmitted to hospital in March 2014 following a fall. His blood tests now showed a significantly disordered liver function. Liver function tests were requested but the request was declined for reasons of "demand management" as a previous report was issued less than three days previously. (5) The test results were not acted upon and Mr Pugh was subsequently discharged from hospital. Expert advice received at inquest suggested Mr Pugh should

	have remained in hospital for further treatment. (6) Mr Pugh was readmitted in May 2014 when he started to bleed from his ilieostomy. (7) Cerith Wyn Pugh passed away on 20th May 2014.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed this matter 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: That referrals to consultants at Withybush General Hospital are routinely being dealt with by middle grade doctors and, if in the opinion of the middle grade doctor, the matter then needs a referral to a consultant only then is the matter passed to a consultant. All consultant referrals should be seen by consultants in the first instance. Expert evidence received at the inquest described this practice as not being best practice. That liver function tests were requested but the Health Board declined to undertake these for reasons of demand management on the basis tests had been done some three days earlier. Expert evidence received at the inquest was highly critical of this practice. Whilst 72 hour testing is in accordance with guidance contained in guidance from the Association for Clinical Biochemistry and the Royal College of Pathologists both documents are clear that the guidance must be capable of being overridden if clinically appropriate. There was no evidence of any mechanism to override the guidance or, if such guidance existed, that it was known to staff.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 the 21 September 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 Person: [redacted] 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 27 July 2016**	**Signed: J M Layton**