REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive of West Wales General Hospital Glangwili Carmarthen**
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 14th May 2013 I commenced an investigation into the death of Robert Erryl Jones then aged 62. The investigation concluded at the end of the inquest on 18th March 2014. The conclusion of the inquest was a narrative conclusion namely that the deceased had died as a result of complications following necessary bowel surgery. The medical cause of death was: 1(a) multi-organ failure 1(b) peritonitis 1(c) post surgery for bowel cancer
4	**CIRCUMSTANCES OF THE DEATH** (1) Mr Jones was admitted to Glangwili Hospital on 21st March 2013 for a bowel operation which was undertaken the following day. Mr Jones remained in hospital following the operation. (2) Due to his declining health an emergency CT scan was arranged for the 8th May 2013. (3) There was an unreasonable delay in making the results of the CT scan available to the ITU and Surgical teams involved in Mr Jones' care. The report was not written up for some considerable time after the scan. (4) When the results were made available there was a further unreasonable delay on the part of the ITU and Surgical teams in acting upon those results. (5) This led to a significant delay in further surgery being performed. (6) It became evident during the course of the inquest that this was not an isolated incident and this failure to pass over and act on CT scan results continues to occur.
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** is as follows: That when a CT scan is performed the results should be made available promptly to the departments involved in the care of the patient and where appropriate the results should be acted upon without delay and within a reasonable time-scale.
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 15th May 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: [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	**20 March 2014** **Signed:**