Nicola Jones
Assistant Coroner for North West Wales

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1. **CHIEF EXECUTIVE BETSI CADWALADR UNIVERSITY HEALTH BOARD**

CORONER

I am Nicola Jones, assistant coroner, for the coroner area of North West Wales

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.

INVESTIGATION

On 28 January 2016 I commenced an investigation into the death of Simon Willans Date of Birth 29/10/1973. The investigation has not yet concluded and the inquest has not yet been heard.

CIRCUMSTANCES OF THE DEATH

Mr Willans' General Practitioner telephoned Ysbyty Gwynedd on 25 January 2016 to try to have Mr Willans admitted as an urgent case. Mr Willans was admitted the next day to the ambulatory care unit at Ysbyty Gwynedd. His presentation was one of breathlessness with recent loss of consciousness. Also his right calf was swollen some 3.5 centimetres more than the left. Nurse Practitioner [redacted] listed 4 differential diagnoses as follows :" 1. Orthostatic hypotension, 2. ? viral illness, 3. ? hyperthyroid, 4. ?? DVT/PE.
Blood tests revealed a positive D Dimer. An ECG was abnormal (this was dismissed by Nurse Practitioner [redacted] as there was a reference in the notes that in 2009 this had been attributed to anxiety but the GP emphasised that the patients symptoms were not due to anxiety from the outset. The ultrasound scan did not reveal any DVT but did not image the swollen calf. Blood gases were abnormal. The patients mother had had a Pulmonary Embolism but this information was not elicited from the patient. Mr Willans was discharged on the same day with a diagnosis of orthostatic hypotension and anxiety. A letter was faxed to the GP on 27/01/2016 setting out the test results and recommended that GP start the patient on betablockers. Mr Willans died on 27/01/2016 from a pulmonary embolism.
North Wales Police have conducted an investigation into a possible offence of gross negligence manslaughter but a decision was made in 2017 by the Crown Prosecution Service not to pursue a criminal investigation

CORONER'S CONCERNS

During the course of the investigation my inquiries 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) BCUHB have only just commenced an SIR on this matter and the ambulatory care unit, its structure, practices, systems, staff have not been effectively scrutinised following Mr Willans death in direct contravention of the policy of BCUHB on reporting and given this the following concerns do not appear to have been addressed potentially compromising patient safety until the conclusion of the SIR
(2) [redacted] the Consultant in charge of the unit did not make any entries in any of the notes for Mr Willans . There is no record of him examining the patient, the abnormal test results, the detail of

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the ultrasound scan.

(3) Mr Willans appears to have been discharged by a Nurse Practioner [redacted] who had no involvement in the care of Mr Willans. [redacted], or any other doctor does not appear to have been involved in the discharge of Mr Willans. Nurse Orlagh Jones adds another diagnosis to the GP letter over and above that of her colleague despite never seeing the patient.

(4) There is insufficient safety netting for this patient. He was not told what to do in the event of a worsening of his condition. The letter to the GP was faxed the day after discharge by which time he had died

(5) The history recovered by Nurse Practitioner [redacted] is inadequate in that it did not elicit family history of Pulmonary Embolism

(6) Heparin was not commenced even though a DVT /PE was one differential diagnosis

ACTION SHOULD BE TAKEN

In my opinion urgent action should be taken to prevent future deaths and I believe you AND your organisation] have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 30 November 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [redacted], [redacted] GP

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.

DATE 05/10/2017 **Nicola Jones**

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