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 8th of January 2015 I commenced an investigation into the death of Kay Michelle Sheard (DOB 6.1.73, DOD 6.1.15). The investigation concluded at the end of the inquest on the 16th of December 2015. The cause of death was 1(a) Unascertained and I recorded an Open Conclusion.
4	**CIRCUMSTANCES OF THE DEATH** The Circumstances of the death are that on the 6th of January 2015 the Deceased underwent an outpatient procedure under sedation at Glan Clwyd HGospital for the removal of gall stones form the bile duct. Upon completion of the procedure she went into cardiorespiratory failure for reasons which could not be established at a Post Mortem nor from evidence at the inquest.
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 :- During the procedure the Deceased's oxygen saturations were being monitored by a pulse oximeter for which I was advised that the alarm settings are routinely set at 85%. However all evidence indicated that it was not the actual level of reading which would be significant for a patient but rather the amount by which saturations had dropped from the patient's normal base level. Notwithstanding this, the evidence indicated that this would not be taken into account when fixing an alarm setting level and I am therefore concerned that there exists a potential risk to patients which could be reduced or eliminated by ensuring that the alarm level correctly reflects the individual patient's condition.

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 15th February 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] (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] 21st December 2015 [SIGNED BY CORONER]**