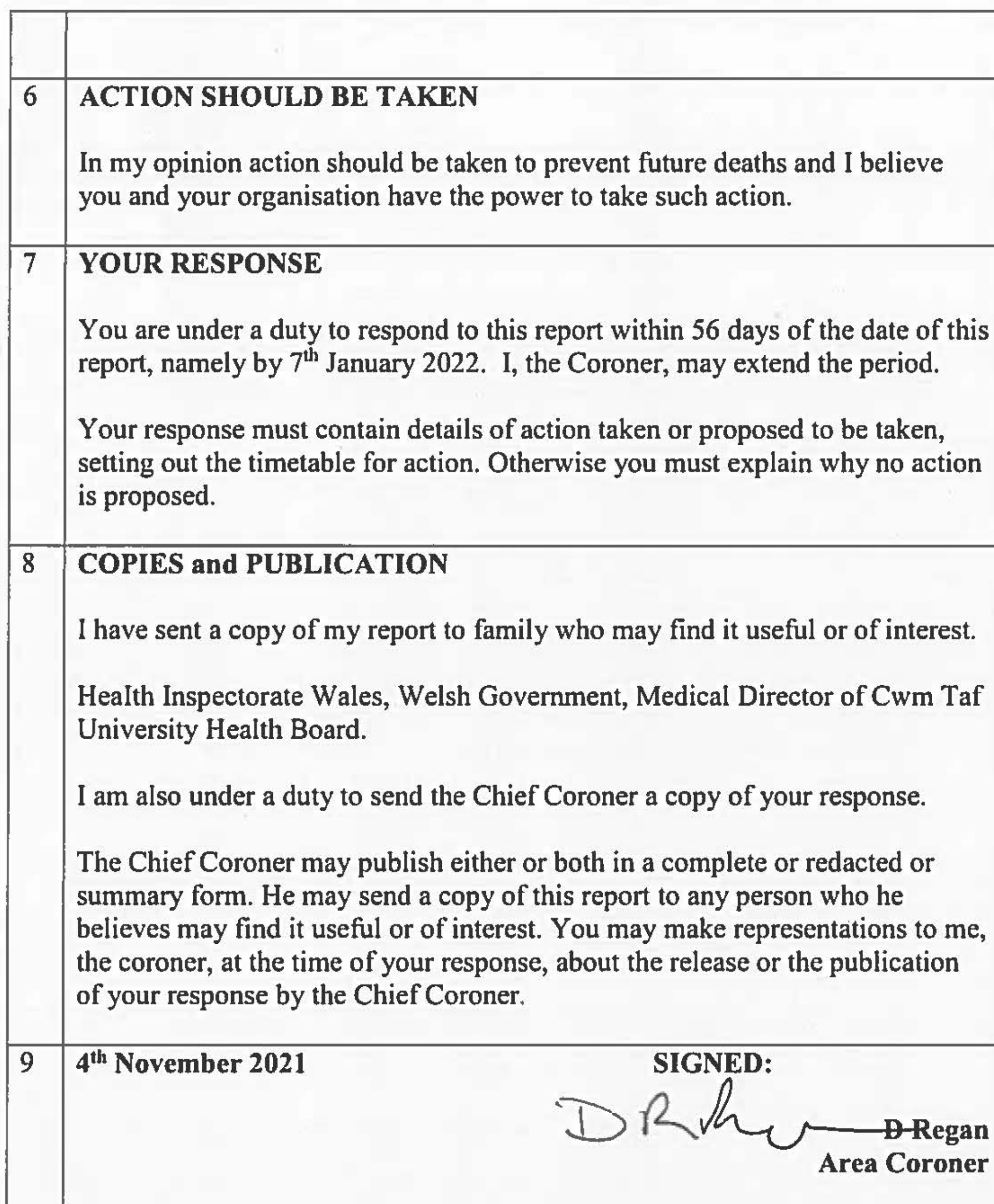
ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive of the Cwm Taf University Health Board**
1	**CORONER** I am David Regan, Area Coroner, for the Coroner's area of South Wales 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** A Coronial investigation was commenced on 29th March 2021 into the death of Robert Wright. The Investigation concluded at the end of the inquest which I conducted on 4th November 2021. The conclusion was that Mr Wright died as the result of natural causes. The medical cause of death was 1 (a) Necrotising cholecystitis; 1(b) Gallstones
4	**CIRCUMSTANCES OF THE DEATH** These were recorded as :- Robert Wright, aged 80, suffered gallstones, which were first diagnosed in 2017. On 14th May 2019 he successfully underwent the removal of a gallstone by ERCP, after which he was referred for consideration of cholecystectomy. Following discharge, he developed biliary sepsis and underwent OGD, which identified suspected haematoma to the stomach wall. He was reviewed in clinic by the Consultant Surgeon on 2nd July 2019, who was unaware of the referral for consideration of cholecystectomy. However, Mr Wright subsequently underwent CT and CTC investigation, which would been indicated in any event. On 26th July 2019 his condition deteriorated and he was taken to the Prince Charles Hospital where he died. Post mortem

	examination identified that this occurred as a result of necrotising cholecystitis caused by gallstones. During the investigation it became clear that the Consultant Surgeon who reviewed Mr Wright on 2nd July 2019 following Biopsy, CT scan and multi-disciplinary discussion after OGD on 13th June 2019 was unaware that Mr Wright had been separately referred for surgical consideration of cholecystectomy following ERCP on 15th May 2019 I would like to make clear that I found that there was absolutely no criticism to be made of that surgeon with respect to his lack of awareness of this issue, and that in the case of Mr Wright I was satisfied that his treatment pathway would not have been altered in any event. However, it is a matter of concern that the surgeon assessing Mr Wright on 2nd July 2021 was not made aware of the related referral, a matter which in other circumstances may give rise to a risk of death.
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) While outpatient referrals from a GP would have been available to the surgeon via an IT system, his evidence was that referrals within the Hospital were made on paper (2) Those paper referrals were routinely not placed on the patient's notes until 2-3 days prior to the clinic, in this case many weeks after being made. (3) In these circumstances there is clearly a risk that a clinician will not have available to them all of the relevant evidence regarding a patent's referrals and condition (4) A busy consultant clinician should not in any event be placed in the position of having to look back through paper records to find a referral for a related condition which he had no reason to expect had been made.



6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 7th January 2022. 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 family who may find it useful or of interest. Health Inspectorate Wales, Welsh Government, Medical Director of Cwm Taf University Health Board. 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	**4th November 2021** **SIGNED:** **D Regan** **Area Coroner**