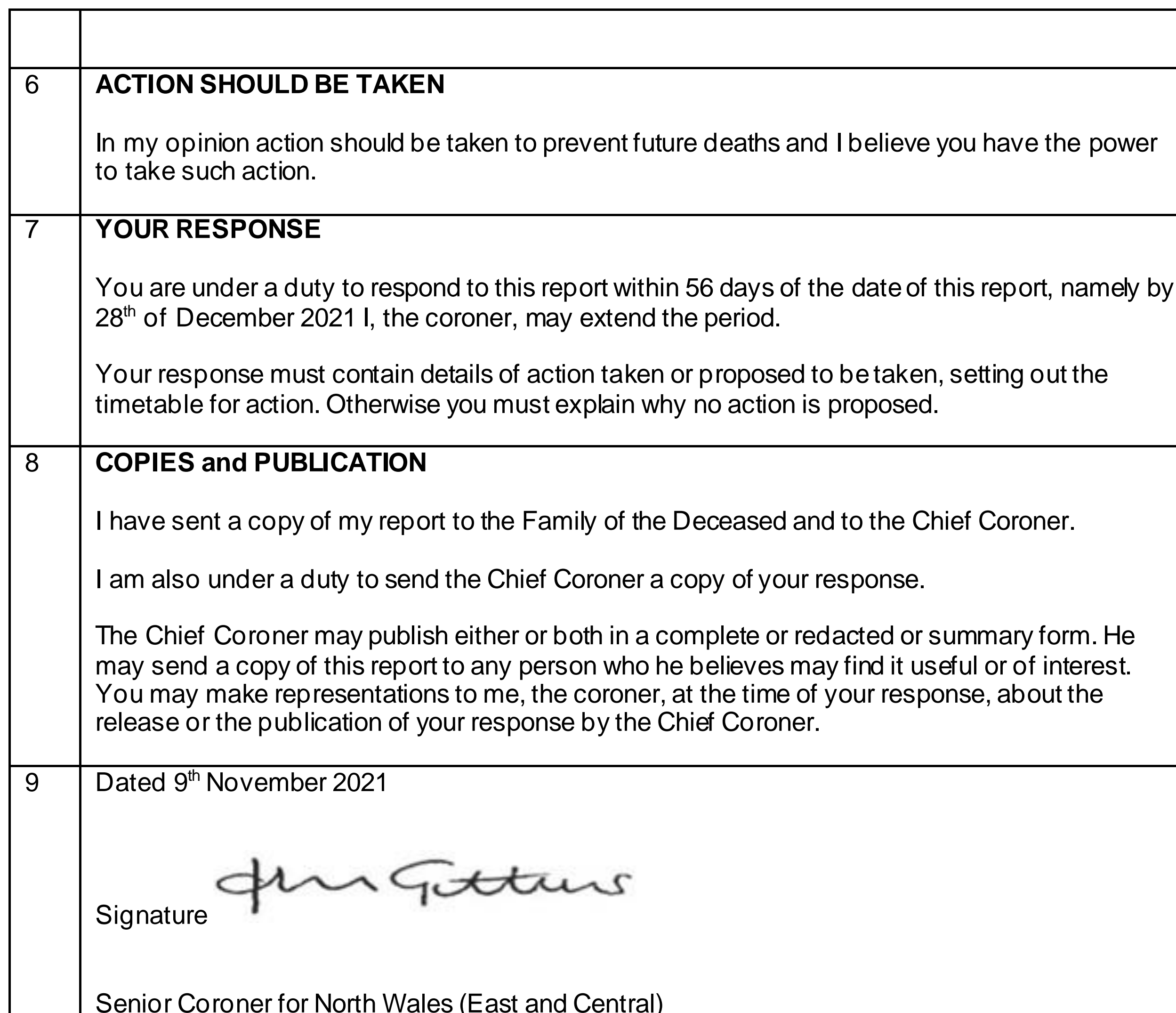
John Adrian Gittins
Senior Coroner for North Wales (East and Central)

	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 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 23rd of August 2019 I commenced an investigation into the death of Susan Merton (DOB 1.3.54 DOD 23.8.19) The investigation concluded at the end of the inquest on the 5th of November 2021. The conclusion of the inquest was one of a death arising from natural causes with the cause of death being 1(a) Sepsis (b) Extrahepatic Biliary Obstructions, Pancreatitis (c) Common Bile Duct Stone 2. Hypertensive Heart Disease
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of this death are that the deceased had undergone a CT scan, the reporting of which failed to identify the presence of a common bile duct stone. When this was later recognised and appropriate treatment was scheduled to take place, the deceased's condition suddenly deteriorated acutely and she passed away at Glan Clwyd Hospital on the 23rd of August 2019.
5	**<u>CORONER'S CONCERNS</u>** 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. Evidence provided to me in the course of the investigation indicated that the Health Board had conducted an investigation and had produced an Action Plan in light of the findings of that investigation. The Action Plan required that the recommendations contained therein be reviewed in a Clinical Governance Meeting on the 5th of August 2021 however for reasons which could not be explained at the inquest, this was not done. 2. On previous occasions I have issued regulation 28 reports expressing concerns that the Health Board continually fail to accomplish actions in circumstances where they have set their own timeframe. 3. I am concerned that as a result of the Health Board failing to follow through with their own actions and recommendations either in a timely manner or in this specific case at all, lives are being put at risk.



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 28th of December 2021 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 Family of the Deceased and to the Chief Coroner. 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 9th November 2021 Signature Senior Coroner for North Wales (East and Central)

Coroner's Office, County Hall, Wynnstay Road, Ruthin, LL15 1YN
Tel 01824 708047 | Fax 01824 708048