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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: the Chief Executive of Cwm Taf Morgannwg University Health Board.**
1	**CORONER** I am Rachel Knight Assistant Coroner for **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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 24/02/2020 I commenced an investigation into the death of Eva Eileen WHEELER. The investigation concluded at the end of the inquest 15th December 2021. I made a determination at inquest that the death should be recorded in a narrative conclusion. The medical cause of death I recorded as: 1(a) Abdominal Perforation 1(b) Sigmoid Volvulus II Asthma, Ischaemic Heart Disease
4	**CIRCUMSTANCES OF THE DEATH** Eva Eileen Wheeler was aged 82 and was an inpatient at Ysbyty Cwm Cynon, for rehabilitation following a soft tissue hip injury. She suddenly developed a bowel obstruction which led to a perforation and died on 17th February 2020. NARRATIVE: Mrs Wheeler developed sigmoid volvulus in the early hours of 17th February, and despite appropriate treatment and diagnosis the same morning, she was not transferred to Prince Charles Hospital for further assessment and care by surgeons. A communication error between staff meant that an emergency ambulance was not called for Mrs Wheeler, and YCC had reached the ceiling of care it could offer her. This failure is unlikely to have changed the outcome for Mrs Wheeler, as her age and co-morbidities meant that she was not a candidate for emergency bowel surgery. She deteriorated rapidly on the ward, and died of an abdominal perforation at around 16:30.
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) The communication error between staff led to a failure to contact an emergency ambulance to transfer a critically ill patient to a major hospital. Since this incident, computerisation has largely replaced written notes in this Trust, and evidence from staff did not satisfy me that any changes were

	embedded on the ground. I am concerned that there is not a clear and robust process in place for documenting, requesting and chasing-up emergency ambulances throughout YCC; (2) A consequence of the communication error (above) was that Mrs Wheeler was given lunch, rather than being kept nil by mouth prior to proposed surgical assessment. There should be a protocol to inform relevant staff when an emergency ambulance is awaited, so that where appropriate, the patient is kept nil by mouth; and (3) The on-call Medical Registrar at Prince Charles Hospital was contacted for advice, since doctors do not work at YCC overnight. Had the on-call Surgical Registrar been consulted, there may have been an earlier diagnosis of suspected sigmoid volvulus. Bowel obstructions are relatively common in an elderly patient cohort, so I question whether provision for joint discussion between the registrars should be built into a protocol.

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 15th February 2022. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the time table 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 Persons: Family of Eva Wheeler Chief Executive of Cwm Taf Morgannwg UHB 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	21/12/2021 Signature R Knight Rachel Knight Assistant Coroner **South Wales Central**