




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

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO: Betsi Cadwaladr University Health Board (BCUHB),</p>
1	<p>CORONER I am John Gittins, Senior Coroner for North Wales (East and Central)</p>
2	<p>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.</p>
3	<p>INVESTIGATION and INQUEST On the 11th of April 2022 an investigation was commenced into the death of Margaret Gertrude Kelly (DOB 21/4/39) who died at Glan Clwyd Hospital on the 31st of March 2022. The conclusion of the inquest on the 5th of October 2023 was by way of a narrative as detailed in paragraph 4 hereof with the cause of death being recorded as 1(a) Multiorgan Failure (b) Intra-abdominal sepsis secondary to bowel perforation 1(c) Abdominal wall hernia (operated) following hemicolectomy for adenocarcinoma of large bowel</p>
4	<p>CIRCUMSTANCES OF THE DEATH On the 28th of March 2022, the deceased underwent an elective surgical hernia repair during which it is probable that her bowel became damaged. The following day she was in pain and attended the Emergency Department at Glan Clwyd Hospital as she had been unable to get an answer from the telephone number which she'd been given. She was not seen by a surgical doctor for several hours and by the following morning, the 30th of March, when her condition had deteriorated considerably, further emergency surgery was undertaken to repair the bowel perforation. As a result of there being several missed opportunities to optimize her care and treatment, Mrs Kelly no longer had the resilience to recover from this procedure and she died at Glan Clwyd Hospital on the afternoon of the 31st of March 2022.</p>
5	<p><u>CORONER'S CONCERNS</u></p> <p>During the course of the inquest, the evidence revealed matters giving rise to concern.</p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <p>Evidence was given at the inquest that when the deceased attended the emergency department it was at level 4 escalation (the highest level which they would escalate to),</p>

	<p>that this was far from unusual and that between March 2022 and the present day, the department would usually be operating between levels 3 & 4.</p> <p>I am concerned that the pressure on clinicians and other staff is unsustainable and that delays in treatment will result in deaths. I do not consider that the operating practices within the department are a direct cause for concern (and as a result I do not require hearing the views of any clinicians in respect thereof), however I am concerned that insufficient or ineffective strategic planning and support is being undertaken and I would therefore wish to hear from those responsible at an executive/managerial level as to the steps which are being taken to reduce pressures within the department at Glan Clwyd.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely 4th December 2023. I, John Gittins, the Coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Family of the Deceased and to the Chief Coroner.</p> <p>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.</p>
9	<p>Dated 9th October 2023</p> <p></p> <p>Signature Senior Coroner for North Wales (East and Central)</p>