Kate Sutherland
Assistant Coroner for North Wales (East and Central)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Betsi Cadwaladr University Local Health Board
1	**CORONER** I am Kate Robertson, Assistant 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 6 December 2021 an investigation was commenced into the death of Hazel Pearson (DOB 28/6/42) who died on 30 November 2021. The investigation concluded at the end of the inquest on 23 November 2023. The conclusion of the inquest was a narrative conclusion as follows : Misadventure contributed to by neglect
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are as follows : Hazel Pearson was admitted into Ysbyty Maelor hospital on 20/8/21 having spent some time at a care home and community hospital before returning to Ysbyty Maelor hospital on 23/11/21. She had known coeliac disease which was recorded on her medical records. Her family had repeatedly informed staff about her coeliac disease. On 26/11/21 she was offered and consumed Weetabix probably believing it was a gluten free equivalent. This caused her to vomit, aspirate, suffer significant oxygenation and subsequent respiratory deterioration which then led to her death from aspiration pneumonia. She died on 30/11/21 at Ysbyty Maelor, Wrexham.
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. Despite the deceased passing away just shy of 2 years ago, there have been inadequate improvements to manage patients with food intolerances and allergies. The Health Board has been working with other organisations in Wales to create an e-learning module and implement the use of red wrist bands for food intolerances / allergies, but this has taken far too long. The e-learning training module was uploaded to BCUHB system the day prior to the Inquest. It is strongly suspected that this was due to the impending Inquest. 2. The Health Board has not investigated the incident at all. A Medical Examiner Report was prepared following the death in November 2021 highlighting the ingestion of gluten in a coeliac patient. I have raised and continue to raise a number of concerns around the inadequacy of governance and poor investigation processes. 3. There were other incidences of gluten ingestion at Ysbyty Maelor and Deeside Community Hospital. On the at least 4 occasions at Deeside Community Hospital there were no Datix reports completed at the time. I was provided with no evidence that additional training, refresher training or induction training deals with when such reports should be made. I cannot be satisfied and reassured that all staff are aware of when to make a Datix report and how to complete this.
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 18 January 2023. I, Kate Robertson, 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 23 November 2023  Signature Assistant Coroner for North Wales (East and Central)