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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Betsi Cadwaladr University Health Board (BCUHB),
1	**CORONER** I am John 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 11th of November 2016 an investigation was commenced into the death of Catherine Lisa Jones (DOB 24/11/80) who died at Wrexham Maelor Hospital on the 10th of November 2016. The conclusion of the inquest on the 8th of December 2023 and a narrative conclusion was recorded in the following terms : In 2012 scans identified an ovarian abnormality and as a result Catherine Jones underwent surgery in relation to the same. Subsequently a biopsy obtained during surgery was wrongly classified as benign and she had no follow up. In June 2016 it was identified that there was the development of a malignant disease process which would probably have been identified sooner if the 2013 sample had been correctly classified. Catherine underwent further surgery at that time but the presence of a soft tissue ovoid lesion was not identified either in surgery (or on a subsequent scan) and she did not undergo chemotherapy. Her cancer progressed and spread quickly due to its aggressive nature and whilst in hospital in October 2016 receiving treatment for complications arising from the same, she contracted a Clostridium Difficile infection which accelerated her deterioration. She died at the Wrexham Maelor Hospital on the 10th November 2016 as a result of widespread metastatic ovarian cancer contributed to by Pseudomembranous Colitis.
4	**CIRCUMSTANCES OF THE DEATH** As per the above narrative conclusion.
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. – It was indicated that for many departments within the health board, surgery was conducted on the basis of "pooled lists" and although evidence was given that the common practice of one of the surgeons was to ensure that they had some form of communication with the patient's consultant prior to surgery (by phone and/or email), there was no evidence that this practice was part of an approved system of work which was documented within the health board's protocols. In the absence of this being a part of an adopted practice and procedure guidance, I am concerned that there may be a lack of cohesive care and treatment for patients undergoing surgery and that future death may occur as a result.
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 6th February 2024. I, John Gittins, 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 12th December 2023  Signature Senior Coroner for North Wales (East and Central)