Kate Robertson
Senior Coroner for North West Wales

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Betsi Cadwaladr University Health Board (BCUHB)
1	**CORONER** I am Kate Robertson, HM Senior Coroner for North West Wales
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 11 May 2017 an investigation was commenced into the death of Nesta Jones (DOB 9 July 1939) who died on 8 May 2017. The investigation concluded at the end of the inquest on 28 February 2024. A narrative conclusion was recorded with the cause of death as:- 1a. Bronchopneumonia 1b. Septic arthritis 2. Immunosuppression and rheumatoid arthritis
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are as follows :- Nesta Jones had been in hospital for 39 days at the point she died on 8 May 2017 at Ysbyty Gwynedd. She was admitted by a GP with suspected septic arthritis of a prosthetic left knee on 31 May 2017. She did not undergo aspiration despite it being indicated by Hospital guidelines, until 5 May 2017, at which point she succumbed to the condition, deteriorated and died. Whilst she was under the care of the physicians primarily and whilst she was referred to a number of orthopaedic doctors with suspected septic arthritis, they did not consider septic arthritis and no aspiration and/or washout was undertaken until 5 May 2017, by which time her condition was irrecoverable.
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 – a. Nesta Jones was seen by a number of orthopaedic doctors of varying grades including consultants. There was a concern during the evidence that junior doctors may not reach a different opinion to their consultant colleagues where the consultants have seen patients prior, and that this opinion is then followed through the patient's journey. If junior doctors are not encouraged to challenge or discuss their findings (which may be different) to their consultant colleagues or have professional discussions, then there is a risk of missing diagnoses. b. The family wrote a detailed urgently marked letter to the Chief Executive on 3 May 2017 whilst Nesta was still in hospital. This requested consideration by him of her care as '*a matter of life or death urgency*'. There was no response. The Health Board did not have adequate and appropriate systems and processes for dealing with such complaints and concerns. c. There was no full investigation undertaken by the Health Board into Nesta's death other than a desktop report, the quality of which was questionable, as the Police were investigating. This means that there were no formal considerations as to immediate actions or learning required to reduce harm and the risk of death. In oral evidence I was informed that there is a new governance process being considered and likely to be in force by April 2024. I have made previous Reports on this precise point and yet the new and improved process is still not in place.
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 24 April 2024. 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 have also sent a copy of this Report to Eluned Morgan, Health Minister, for her information. 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 28 February 2024  Signature Kate Robertson HM Senior Coroner for North West Wales