GRAEME HUGHES

HIS MAJESTY'S SENIOR CORONER

SOUTH WALES CENTRAL CORONER AREA

CORONER'S OFFICE
THE OLD COURTHOUSE
COURTHOUSE STREET
PONTYPRIDD
CF37 1JW

Telephone: [redacted]
Email: [redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive, Cwm Taf Morgannwg University Health Board**
1	**CORONER** I am Kerrie Burge, Assistant Coroner for the coroner area of 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.
3	**INVESTIGATION and INQUEST** On 12th. December 2022, 1commenced an investigation into the death of Clara Novella Winter, aged 77. The investigation concluded at the end of the inquest on 17th. May 2024. At the conclusion of the inquest, the medical cause of death was established as 1a Perforated incarcerated ischaemic bowel 1b Intra abdominal adhesions in the setting of elective cholecystectomy (operated on 14/11/2022) and previous pelvic surgery My conclusions were that Clara Novella Winter died at Prince Charles Hospital on 19th. November 2022 as a result of a perforated incarcerated ischaemic bowel. I reached a narrative conclusion that following routine and uneventful surgery to remove her gall bladder, Mrs. Winter's bowel became inflamed and resulted in complications with her existing hernia, including further adhesions, incarceration of the bowel, ischaemia and a bowel perforation. Emergency surgery was carried out to repair this but sadly Mrs. Winter was unable to recover.

[redacted]

4	**CIRCUMSTANCES OF THE DEATH** Mrs. Winter was admitted to hospital on 14th. November 2022 for an elective laparoscopic cholecystectomy. She had undergone surgery some years ago which had resulted in complications, including an irreducible hernia and adhesions. Her condition deteriorated the following day, reaching crisis point at around 23:00. Subsequent emergency surgery revealed that whilst the upper abdomen area was normal, the existing hernia had changed, an ischaemic patch had developed along with a bowel perforation. A right hemi colectomy with side to side anastomosis was necessary. Mrs. Winter survived the surgery but later died.
	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.
5	Following Mrs. Winter's death, her family raised concerns about her post operative care. I did not find that her post operative care more than minimally contributed to Mrs. Winter's death. However, following an internal review: 1. The Health Board accepted that significant learning was required by staff regarding timeliness of escalation and maintenance of fluid balance charts and recommended that all registered nurses from surgical wards should attend an 'Acutely Unwell' study day, before the end of 2023. 2. This 'significant learning' has not been fully rolled out due to resourcing issues. No completion date could be provided to me because the training is not considered to be compulsory.
	ACTION SHOULD BE TAKEN
6	In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.
	YOUR RESPONSE
7	

[redacted]

	You are under a duty to respond to this report within 56 days of the date of this report, namely by 22nd. July 2024. 1, 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 family who may find it useful or of interest. 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	28 May 2024 **SIGNED:** KBurge Kerrie Burge Assistant Coroner for South Wales Central Coroner Area

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Eich cyf/Your Ref:
Ein cyf/Our Ref: [redacted]
Ebost Email:
Dyddiad/Date: 22 July 2024

Private & Confidential
Kerrie Burge
Assistant Coroner
South Wales Central Coroner Area
Coroner's Office
The Old Courthouse
Courthouse Street
Pontypridd
CF37 1JW

Dear Ms Burge,

I am writing in response to a Regulation 28: Report to Prevent Future Deaths dated 28 May 2024 issued by Assistant Coroner for South Wales Central Ms Kerne Burge, following the Inquest touching upon the death of Mrs Clara Novella Winter who died at Prince Charles Hospital on 19th November 2022.

An inquest held on 17 May 2024 concluded that, following routine and uneventful surgery to remove her gall bladder, Mrs. Winter's bowel became inflamed and resulted in complications with her existing hernia, including further adhesions, incarceration of the bowel, ischaemia and a bowel perforation. Emergency surgery was carried out to repair this but sadly Mrs. Winter was unable to recover.

The matters of concern that were identified during the inquest into Ms Winter's death were that, following an internal review:

1. **The Health Board accepted that significant learning was required by staff regarding timeliness of escalation and maintenance of fluid balance charts and recommended that all registered nurses from surgical wards should attend an 'Acutely Unwell* study day, before the end of 2023.**

2. This 'significant learning* has not been fully rolled out due to resourcing issues. No completion date could be provided to me because the training is not considered to be compulsory.

The Acutely Unwell Patient study day is facilitated by the outreach teams within Cwm Taf Morgannwg UHB. The course runs monthly within Prince Charles, Royal Glamorgan and Princess of Wales hospitals. Registered nurses are booked on by the ward manager. It is a one-off, non-mandatory course but it is advisable that staff complete at least every 3 years.

The Acutely Unwell Patient programme includes sessions on the National Early Warning Score (NEWS), Situation, Background, Assessment and Recommendation (SBAR) communication to Acute Kidney injury and Fluid Balance, Learning disability and reasonable adjustments in acute illness, A-E assessment and sepsis.

From September 2024 the Acutely Unwell Course will be a CTM UHB standardised course available on ESR (Electronic Staff Record) for staff to book and have a larger capacity of training numbers of 25-30 spaces per month. The course is promoted via posters and staff email and all ward managers and senior nurses are encouraged to book staff members onto the course.

For the surgical wards within PCH these are the current numbers trained and booked to attend the course:

PCH Surgical wards
Acutely Unwell Patient Training Day

PCH Surgical Ward	No of Registered Nurses	Staff trained	Compliance	Staff to be trained
5	21	19	90%	2 booked 2024
6	22	17	77%	5 booked 2024
7	16	4	*26%	12 booked 2024
8	20	15	75%	5 booked 2024

*2 courses cancelled due to doctor's strikes in January and March 2024 impacting on compliance

Acutely Unwell Course dates for 2024

24th July
27th August
3rd September
11th October
12th November
2nd December

As can be seen from the figures above, all staff have either completed the course or will have attended the Acutely Unwell Patient study day within the surgical wards in PCH.

From August 2024 Outreach staffing will be at full establishment of 7wte within PCH (Prince Charles Hospital), RGH (Royal Glamorgan Hospital), POW (Princess of Wales) hospital sites.

In addition to the Acutely Unwell Study Day, the outreach team deliver training on the deteriorating patient via induction for graduate nurses biannually and by student nurse learning sessions. The teams also provide ad hoc bedside teaching as well as bitesize sessions.

Further training on the deteriorating patient is provided via the ALERT (Acute Life-Threatening Events Recognition and Treatment) course. The course is facilitated by the senior nurse for Acute Deterioration and Outreach services and supported by the resuscitation service, outreach and ANP Advanced Nurse Practitioners.

The Health Board take all matters of concern seriously and actively addresses issues to prevent reoccurrence in future. In this instance, the full complement of outreach staff will ensure that the training is run monthly and that all staff who need to complete the training from surgical wards will have done so by the end of 2024.

Yours sincerely,

[redacted]

Prif Weithredwr/Chief Executive