GRAEME HUGHES

HIS MAJESTY'S SENIOR CORONER

SOUTH WALES CENTRAL CORONER AREA

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

[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, I commenced 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.

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.
5	**<u>CORONER'S CONCERNS</u>** 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. 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.
6	**ACTION SHOULD BE TAKEN** 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.
7	**YOUR RESPONSE**

[redacted] [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. I, 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:**  Kerrie Burge Assistant Coroner for South Wales Central Coroner Area

[redacted] [redacted]