IN THE PEMBROKESHIRE & CARMARTHENSHIRE CORONER'S COURT

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Clinical Director, Hywel Dda University Local Health Board, Ystwyth Building, Hafan Derwen, St David's Park, Jobswell Road, Carmarthen, SA31 3BB** **2. The Chief Executive NHS Wales, Welsh Assembly, Cathays Park, Cardiff, CF10 3NQ**
1	**CORONER** I am Paul Bennett, acting senior coroner, for the coroner area of Pembrokeshire & Carmarthenshire
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 14th February 2020 I commenced an investigation into the death of Susan Margaret Williams aged 73. The investigation concluded at the end of the inquest on 19th June 2024. The conclusion of the inquest was a natural causes one with the medical cause of death recorded as: 1a. Cardiorespiratory failure. 1b. Lung Fibrosis. Cor Pulmonale.
4	**CIRCUMSTANCES OF THE DEATH** Susan Margaret Williams had been admitted as an emergency patient at 4.23am on the morning of the 14th July 2019 into the Accident and Emergency Unit of Withybush Hospital, Haverfordwest with a suspected diagnosis of sepsis, complaining of abdominal pain. She underwent care and treatment consistent with that diagnosis. Despite appropriate measures being taken, Mrs Williams deteriorated and died from Cardiorespiratory failure due to lung fibrosis and Cor Pulmonale.
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 could 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 initial triage and attendance by a clinician, a number of appropriate medications were prescribed and entered on the In-Patient Medication Administration Record. These comprised an analgesic, an anti-emetic and two antibiotics.

	1. The Medication Record shows the time that the medications are administered, but not the time that they were prescribed. In this case the evidence showed that the antibiotics were administered later than the other medications and there was a conflict between the prescribing clinician and the nurse administering the medications as to whether all of the medications had been prescribed at the same time. The concern in this case related to a potential delay in the administration of the antibiotic medication (considered to be a significant sepsis treatment), there being a period of some 90 minutes between the times entered on the Record for the administration of the analgesia and the anti-emetic. I consider this to be a concern as the lack of a recorded time of prescription highlights the possibility that there is no immediate means of referencing whether a prescribed medication has been administered within a reasonable time of it being prescribed. Although the factual findings in this inquest did not show a causative connection between the delays in the administration of the antibiotics, I consider this to be a concern that may result in a potential future death. 2. In the course of the evidence, it also became apparent that the Accident & Emergency Record Card (known as the "Cas Card") has no similar provision to record medication prescription and administration within its content. This would have been a separate point of reference for this purpose. Both of the documents referenced are understood to be used across the NHS in Wales and not confined to the Health Board in whose care Mrs Susan Margaret Williams was at the time.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you your organisation(s) 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 by 16th August 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 the Chief Coroner and to the following Interested Persons – [redacted] and [redacted], the family of Mrs Susan Margaret Williams. 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	**20th June 2024**