GRAEME HUGHES

HIS MAJESTY'S SENIOR CORONER

SOUTH WALES CENTRAL CORONER AREA

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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:** **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 3 May 2023 I commenced an investigation into the death of Annette Lewis, which was concluded at the end of the inquest on 24/02/2025. The medical cause of death was established as: **1a Peritonitis and Upper Gastrointestinal Haemorrhage** **1b Perforated Pyloric Ulcer** I reached a narrative conclusion: Annette Lewis, aged 73, re-presented at hospital on 15th. April 2023, for the second time that week, with worsening abdominal pain. Annette was discharged from hospital in the early hours of 16th. April, without full consideration of her symptoms and test results. Annette was declared deceased at her home [redacted] on 18th. April 2023. On the balance of probabilities, Annette would have survived if she had been referred for a surgical review and treatment rather than being discharged.
4	**CIRCUMSTANCES OF THE DEATH**

	These were recorded as: Annette Lewis attended the Emergency Department on 9th. April 2023 with abdominal pain and was discharged with antibiotics and painkillers. She re-attended the Emergency Department with worsening abdominal pain on 15th. April 2023 and was discharged on 16th. April with further medication and an outpatient referral for gastroenterology. The decision to discharge was made without sufficient weight being given to an internal Health Board document for investigating "Abdominal Pain in the Elderly" and Annette's blood tests results had not been reviewed.
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: Annette should have been referred for surgical review rather than being discharged. Work on a "Failed Discharge" policy has been ongoing for some time. When implemented, patients re-attending Emergency Departments in similar circumstances would be automatically and swiftly filtered to the appropriate specialist team, which would reduce the risks for those individual patients and reduce pressures and the consequent risk of errors within Emergency Departments. Progress with this policy has been difficult and there is no definitive timescale for implementation.
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** You are under a duty to respond to this report within 56 days of the date of this report, namely by 31st. July 2025. 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 have also sent a copy to the Chief Executive, NHS Wales. 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	6 March 2025 **SIGNED:**  Kerrie Burge Assistant Coroner for South Wales Central Coroner Area