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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS ***THIS REPORT IS BEING SENT TO:*** ***The Chief Executive Cardiff & Vale University Health Board.*** ***Cabinet Secretary for Health and Social Care***
1	***CORONER*** I am Kerrie Burge, H.M. 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 18 October 2024 I commenced an investigation into the death of Gareth Idris Johnson. The investigation concluded at the end of the inquest on 01/09/2025. I made the following determinations: Gareth Idris Johnson, aged 41 died at University Hospital of Wales on the 16th of October 2024 due to complications following a catheter directed thrombolysis procedure. I reached a narrative conclusion: After undergoing uneventful catheter directed thrombolysis, Gareth's anti coagulation medication management was sub optimal for a number of reasons, the most significant of which was lack of clarity about the appropriate level of heparin to be administered. On the balance of probabilities, sub therapeutic anti coagulation medication more than minimally,

	negligibly or trivially contributed to Gareth's death and it is more likely than not that Gareth would have survived had his medication been delivered appropriately The medical cause of death was: **1a Cardiac arrest** **1b Pulmonary Embolus**
4	**CIRCUMSTANCES OF THE DEATH** Gareth Idris Johnson attended The Grange hospital on 12.10.2024 and was diagnosed with a moderate to large volume bilateral pulmonary embolism with acute right heart strain. It was the weekend and therefore Gareth was transferred to University Hospital of Wales for catheter directed thrombolysis. Following the procedure, Gareth was one of a small number of patients transferred out of the Critical Care Unit to PACU due to planned building maintenance works. Gareth's post operative medication management was sub optimal for a number of reasons, including the impact of being cared for outside the main Critical Care Unit.
5	**<u>CORONER'S CONCERNS</u>** During 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: Due to the age of the hospital building, maintenance is a constant battle. There are also capacity issues in Critical Care due to patient volumes. Building infrastructure had been a constant feature on the corporate risk register and was now scored at its highest level. Whilst measures have been put in place to safeguard against moving patients who require critical care from the Critical Care Unit, there remained fears that these systems would fail during times of pressure.

[redacted]

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 10th November 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 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. She may send a copy of this report to any person who she 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	12 September 2025 **SIGNED:** [redacted] Kerrie Burge, H.M. Coroner for South Wales Central Coroner Area