**GRAEME HUGHES**

**HIS MAJESTY'S SENIOR CORONER**

**SOUTH WALES CENTRAL CORONER AREA**

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

[redacted]

**ANNEX A**

## 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**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>[redacted], **Chief Executive Cardiff & Vale University Health Board** |
| 1 | **CORONER**<br><br>I am **Rachel Knight H M Coroner**, for the coroner area of South Wales Central. |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 20 March 2025 I commenced an investigation into the death of Joan Marilyn READ . The |

| | |
|---|---|
| | investigation concluded at the end of the inquest on 03/02/2026 . The conclusion of the inquest was a narrative. The medical cause of death was recorded as follows:<br><br>**1a Bronchopneumonia**<br><br>**1b Frailty due to B12 deficiency**<br><br>**1c Pernicious anaemia**<br><br>**II COVID 19 infection, hypothryoidism, delirium** |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>These were recorded as :-<br><br>Joan Marilyn Read was aged 91 when on 18th March 2025 she died at the University Hospital of Wales, Cardiff. Joan had been an inpatient in August 2023, and was discharged home whilst a blood test result was pending. There was a missed opportunity to communicate a severely deranged B12 result, and as a consequence, it was not treated in hospital, nor in the community. Joan was admitted to the same hospital in January 2025 with a significant deterioration in her physiological reserves, she was frail and had been less compliant with her medication. Sadly, despite all treatment available, Joan did not recover and continued to decline to her death.<br><br>Joan was treated at the UHW from mid-January until her death on March 18th 2025. It is more likely than not, that the failure to address her B12 deficiency more than minimally contributed to her death.<br><br>The Inquest focused upon:-<br><br>- the processes surrounding deranged test results and their onward communication for action |
| 5 | **<u>CORONER'S CONCERNS</u>**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows.<br><br>(1) Evidence revealed that a single medical consultant is responsible for geriatric perioperative care (POPS). There is no cross-cover during periods of expected and unexpected absence. There is |

| | |
|---|---|
| | a risk that deranged test results or other urgent results will be missed when that doctor is absent;<br><br>(2) Without a robust system for cross-cover 52 weeks per year recognised within another doctor's job plan, this risk will likely continue, despite huge positive strides in communicating test results within the Trust. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 3rd April 2026. I, the Coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to family and the clinician concerned, who may find it useful or of interest.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | 4 February 2026 |

**SIGNED:**

Rachel Knight H M Coroner for South Wales Central Coroner Area

Coroner's Office, The Old Courthouse, Courthouse Street, Pontypridd, CF37 1JW

Phone/Ffôn (01443) 281100 Fax/Ffacs (01443) 485862