

GRAEME HUGHES CORONER'S
THE OLD
SENIOR CORONER
PONTYPRIDD SOUTH WALES
CORONER AREA CF37 1JW



OFFICE
COURTHOUSE HIS MAJESTY'S
COURTHOUSE STREET

CENTRAL

Telephone: 01443 281100

ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REPORT TO PREVENT FUTURE DEATHS REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013 Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).
1	CORONER I am Gaynor Kynaston HM Coroner, for the coroner area of South Wales Central.
2	DATE OF REPORT 29th July 2026
3	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.

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

Phone/Ffôn (01443) 281100

Fax/Ffacs (01443) 485862

4	THIS REPORT IS BEING SENT TO 1. Welsh Government 2. Cardiff and Vale University Health Board You are under a duty to respond to this report within 56 days of the date of this report, namely by 23rd September 2026. I, the coroner, may extend the period if an appropriate application is made.
5	YOUR RESPONSE 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.

6	<u>SUMMARY OF CORONER'S CONCERN</u> I have concerns that avoidable deaths will occur in the future due to overcapacity of patients, under-establishment of staff and exit block. Taken together these three issues are causing avoidable delays, treatment not being given and harm/death to patients. I have further concerns that, because this is a nationwide issue, there is a culture of acceptance which precludes radical changes being made that will make a real difference to patient care and bring an end to deaths occurring due to insufficient staff and overcapacity and exit block.
7	ACTION SHOULD BE TAKEN In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.

INVESTIGATION AND INQUEST

On 11/04/2022 I commenced an investigation into the death of Alan REES. The investigation concluded at the end of the inquest on 16/07/2026.

The medical cause of death was:

1a Ischaemic Heart Disease with Hypovolaemia and Toxaemia caused by Clostridium Perfringens infection in the left hemithorax

1b

1c

1d

II End stage renal disease

8

The circumstances were :-

Mr Alan Rees a 73 year old gentleman died at the University Hospital of Wales on 5/4/22 following a cardiac arrest during haemodialysis. Mr Rees had been admitted on 14/3/22 where he was diagnosed with a hydropneumothorax which was successfully drained. Aspirate initially did not yield any growth of bacteria, however, a subsequent sample taken from the drain did grow Clostridium Perfringens. This was recognised only after he had been discharged on 26/3/22 and despite advice to observe him this was not communicated to those who planned to see him in the days after discharge. Mr Rees attended for dialysis on four occasions post discharge where he did not show signs or symptoms of infection, his last dialysis being 1/4/22. He attended the ED on 4/4/22 at 12:35 with a 2 day history of chest pain and shortness of breath and was found to have a hydropneumothorax which was drained. He was also diagnosed with empyema and sepsis which were not treated during his admission before his cardiac arrest at around 22:00hours. Mr Rees had a number of co-morbidities affecting his ability to recover and

his end stage renal failure interfered with his ability to deal with infection, notably masking any symptoms he had during his initial attendance at the Emergency Department. Mr Rees had significant ischaemic heart disease and cardiac failure, his heart pumping only 10% of the volume of a normally functioning heart. He died as a result of significant heart failure and sepsis. It cannot be established on the balance of probabilities whether earlier recognition and treatment of sepsis or treatment of the C Perfringens at an earlier stage in the disease process would have altered the outcome.

Conclusion:

Mr Alan Rees, a 73 year old gentleman, died at the University Hospital of Wales on 5/4/22 following a cardiac arrest during haemodialysis. He had been diagnosed with a left sided hydropneumothorax when he attended ED on 4/4/22 at 12:35 which was drained. Treatment prescribed in the Emergency Department had not been administered before he suffered a cardiac arrest at around 22:00 hours. He died as a result of ischaemic heart disease, heart failure and sepsis. Due to his significant comorbidities, in particular renal and cardiac failure interfering with his body's ability to recover from such an insult, it cannot be established on the balance of probabilities whether earlier recognition and treatment of sepsis or would have altered the outcome.

CIRCUMSTANCES OF DEATH

9

Mr Alan Rees, a 73 year old gentleman, was admitted to the University Hospital of Wales in Cardiff with facial swelling, peripheral oedema and breathlessness. He had significant co-morbidities, most notably, end stage renal failure and congestive cardiac failure. He had bilateral pleural effusions of a transudative nature. The effusions were drained and the pleural aspirate sent for analysis – both of which were negative. A further sample was sent to the laboratory due to concerns about malignancy. This further sample, which grew *Clostridium Perfringens*, was not reported upon until after Mr Rees had been discharged. On the basis he was clinically well at the time with normal observations, bloods and inflammatory markers and two previous negative samples the bacterial growth was thought to be due to contaminants and antibiotics were not prescribed. Mr Rees had four sessions of haemodialysis without incident following discharge with his observations being normal on each occasion and no reports of symptoms indicating infection. Two days after his last haemodialysis session, Mr Rees re-presented to the Emergency Department on 4/4/22 at 12:35 hours with shortness of breath, pressure in his chest and aching down both arms. His respirations were high at 32, his temperature was normal and his blood pressure and pulse were on the low side, the latter two being normal for him. He was categorised in triage as 3 meaning to be seen within the hour. There was a delay bringing him into the department due to lack of space and his investigations were not undertaken until after 14:00 hours. The main focus at the time was draining of the hydropneumothorax which was carried out by the Emergency Department doctor. An ECG was also planned. Mr Rees blood results, received at 16:10, showed extremely high inflammatory markers indicating overwhelming infection. His potassium level was also raised. Mr Rees was seen by the medical doctor at 17:55 and by the medical consultant at 19:00. He was prescribed Calcium Gluconate and intravenous antibiotics. The working diagnosis was Hydropneumothorax with End Stage Renal Failure and Empyema with *Clostridium Perfringens*.

Due to the acuity within the Department, neither of the prescribed medication was administered to Mr Rees before he arrested on the renal ward, nor was the ECG undertaken. He was in the Emergency Department for eight a half hours (including the time he spent on the ambulance) without any medication being given. Haemodialysis was commenced around 21:40 hours. Mr Rees pressed the call bell at 21:55 due to feeling nauseous and was given intravenous Cyclizine for this, however, as the nurses were making him more comfortable he suffered a cardiac arrest from which he did not recover.

CORONER'S CONCERNS

During the course of the inquest I heard evidence 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:

I heard in evidence from emergency medical and nursing staff that, notwithstanding Mr Rees died during the pandemic when overcrowding became the norm, overcapacity, under-establishment of staff and exit block has not materially changed since Mr Rees' death. I was informed the establishment of staff within the department is based on the number of patients being between 60-70 and was very concerned to learn that when Mr Rees was admitted there were 187 patients within the department. The evidence was that *"the constraints on nurses now are about the same as when Mr Rees died."* I had further concerns upon hearing that patient numbers have been increasing year on year by 7% and while the Health Board has implemented changes bringing about some improvements, they have not made sufficient impact to satisfy me that future deaths due to over capacity, insufficient staff and exit block will not continue to occur. Mr Rees was within the Emergency Department (including the time spent on the ambulance) for eight and a half hours without the administration of prescribed medication despite clear signs of overwhelming infection. The staff had too many patients with competing priorities to care for.

The concerns I have were confirmed by the evidence I heard during the course of the inquest such as *"occupancy is substantially greater than space it's not just about numbers, patients aren't moved through the department there is huge moral injury to staffexit block is still happening, with insufficient space to move patients into.....it has been on the health boards risk register for a number of years"* the latter comment suggesting that the risk has been ongoing without resolution for some years.

I was made aware during the course of the inquest that a joint letter from the Royal College of Emergency Medicine had recently been sent to the Welsh Government raising the concerns I have highlighted above.

I am informed that the Health Board in conjunction with the Emergency Department has done all within its powers to bring about positive change with some success, and I am keen to learn what collaborative measures will be taken by Cardiff and Vale University Health Board together with the Welsh Government to resolve what has become a chronic, unacceptable and dangerous situation to ensure the care and treatment provided to patients within the Emergency Department is timely and safe.

COPIES AND PUBLICATION OF THIS REPORT

I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it.

I also may send a copy of the report to any other person who I believe may find it useful or of interest.

I can confirm I have sent the report to:

[please do not use individual's names, but instead roles/titles]

1. Mr Rees' Family

2. Public Health Wales

I also have a duty to send a copy of the report to the Chief Coroner.

You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's [PFD Publication Policy \(2026\)](#). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.

28 July 2026

SIGNED:



Gaynor Kynaston, HM Coroner for South Wales Central Coroner Area