REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **BCUHB c/o Litigations, Wrexham Maelor Hospital, Croesnewydd Road, Wrexham**
1	**CORONER** I am JOHN ADRIAN GITTINS, senior coroner, for the coroner area of North Wales (East and 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 the 19th of April 2013 I commenced an investigation into the death of Gwilym Pugh Jones (DOB 24.2.40, DOD 16.4.13). The investigation concluded at the end of the inquest on the 19th of September 2013. The conclusion of the inquest was Accidental Death and the medical cause of death was 1(a) Sepsis 1(b) Peritonitis and Toxic Mega Colon 1(c) Pseudomembranous Colitis (Clostridium Difficile Infection) 2 Diabetes Mellitus and Lacunar Anterior Circulation Stroke.
4	**CIRCUMSTANCES OF THE DEATH** 1. The Deceased had been admitted to the Wrexham Maelor Hospital on the 14th of March 2013 due to an apparent stroke. Whilst a patient at this hospital he developed symptoms which were suggestive of the Clostridium Difficile infection and on the 11th of April by an attending clinician that a stool sample be sent for analysis. This was not done. 2. At the final inquest hearing evidence was given by [redacted] regarding the treatment of Mr Jones and he was unable to account for the failure of obtaining and testing a stool sample and he indicated that it is possible that the final outcome may have been different had this condition been diagnosed and treated sooner.
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 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. – (1) Tests were not conducted despite being required by a clinician and this resulted in a missed opportunity to provide a diagnosis and treatment.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisations 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 20th November 2013. 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] (wife of the Deceased) 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	**[DATE] 25th September 2013 [SIGNED BY CORONER]**