REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** BCUHB, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd LL57 2PW
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 9th of May 2013 I commenced an investigation into the death of Timothy Peter Cowen (DOB 6.9.61, DOD 2.5.13). The investigation concluded at the end of the inquest on the 30th of September 2014 and I recorded a narrative conclusion in the following terms – On the 23rd April 2013 Timothy Peter Cowen underwent an operation at the Maelor Hospital, Wrexham having previously undergone a substantial pre-operative assessment which took into account his severe learning disabilities and significant mobility limitations. The operation itself was uneventful and post operatively he was returned to the ward for ongoing care. He received nutrition by way of a peg feed and his feeding regime had been established over a long period of time such that he would receive nutrition in two daily sessions whilst upright. Post operatively this regime was changed in accordance with recognised dietary practices and he then received a single reduced dose of feed over a longer period whilst being propped up in bed. It is probable that during this period as a result of his existing medical conditions he aspirated resulting in infection. He was assessed as being fit for discharge on the morning of the 25th April 2013, although his actual discharge did not take place until that same evening at which point his carers who knew him best were concerned that his condition may have deteriorated rendering him unfit for discharge. Such concerns were not brought to the attention of nursing or medical staff at that time. Over the course of the next three days his condition continued to deteriorate resulting in his re-admission to the Maelor Hospital on the 28th April 2014. Despite surgical investigation and ongoing support he passed away on the 2nd May 2013 at 21.25 hours on ITU. as a result of Bilateral Extensive Pneumonia with features of Aspiration.
4	**CIRCUMSTANCES OF THE DEATH** The Circumstances of the death are outlined the above narrative conclusion.

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 :- 1. That although a Root Cause Analysis undertaken by the health board has resulted in new training bundles being produced, training is not mandatory for all staff who would require to be made aware of the new procedures and protocols. 2. That whilst there has been established a new role of Acute Liaison Nurse to provide cohesion to the care given to patients requiring additional support, there are only three such ALNs and there is no cover in place when they are absent through illness or holidays.
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 2nd December 2014 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 Person – [redacted] (Brother 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] 7th October 2014 [SIGNED BY CORONER]**