REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive of West Wales General Hospital Glangwili Carmarthen**
1	**CORONER** I am Jonathan Mark Layton, senior coroner, for the coroner area of Carmarthenshire and Pembrokeshire.
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 2nd July 2018 commenced an investigation into the death of Gerwyn James Thomas. The investigation concluded at the end of the inquest on 6th November 2018. The conclusion of the inquest was a narrative conclusion as follows: Following a domestic fall Gerwyn James Thomas was admitted to Glangwili General Hospital on 21 March 2017 with a fractured femur. He underwent surgery but developed an infection, the origin of which is unknown, which caused his death. A referral made to the acute diatetic service was not responded to in a timely manner. Gerwyn James Thomas' compromised nutritional status may have impaired his ability to resist this infection. The medical cause of death was: 1(a) sepsis, multi-organ failure 1(b) infected hip surgery
4	**CIRCUMSTANCES OF THE DEATH** (1) Mr Thomas was admitted to Glangwili Hospital on 21st March 2017 following a domestic fall where he fractured his femur. This required surgery. (2) Mr Thomas was discharged. Subsequently he was readmitted to hospital three times after he developed an infection which was treated but which subsequently resulted in his death. (3) A referral was made to the acute diatetic service which was not acted upon promptly.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed this matter 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. The acute diatetic service lacks sufficient staff to respond to referrals in a timely

	way. 2. The use of the diagnostic tool to assess a patient's nutritional need, which nursing staff apply when a patient is admitted, requires training. When wrongly applied, this diagnostic tool will give an unreliable assessment. Training in the use of this diagnostic tool should be made mandatory for all nursing staff. 3. When a treating doctor identifies a need for a patient to be referred to the acute diatetic service, nursing staff should act upon this referral and in circumstances where nursing staff believe that such a referral is unnecessary this should be discussed at a multi-disciplinary team meeting.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 the 1st January 2019. 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] 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	**6 November 2018** **Signed:**