John Adrian Gittins
Senior Coroner for North Wales (East and Central)

	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 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 21st of April 2021 I commenced an investigation into the death of Nora Jane Foulkes (DOB 13.1.34 DOD 16.4.21). The investigation concluded at the end of the inquest on the 17th of February 2022. The conclusion of the inquest was a narrative in the following terms : The deceased was an 87 year old lady residing in a residential home. In December 2020 she contracted covid which it was thought would prove fatal for her and as a result her medications were appropriately stopped, however she survived this illness and on the 1st of February 2021 her medication regime was reviewed by visiting Advanced Nurse Practitioners who decided that her levothyroxine should be restarted. This decision was shared with the care home but this medication was not recommenced nor was this absence of its administration noted in subsequent ANP visits in March. On the 11th of April 2021 Mrs Foulkes was admitted to Glan Clwyd Hospital where she went on to pass away on the 16th of April. A subsequent post mortem examination established that she had died due to cardiorespiratory failure which was the result of a bronchopneumonia and an existing cardiac condition but that her untreated hypothyroidism had been contributory to her death. The Cause of Death being recorded as 1(a) Cardiorespiratory Failure, (b) Bronchopneumonia and Ischaemic Heart Disease 2. Dementia, Hypothyroidism
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are as detailed in the narrative conclusion referred to above
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. Although the original failure to restart the deceased's treatment for her hypothyroidism would appear to have been discussed and agreed between the Advance Nurse Practitioners and the care home when a medication review was conducted, the deceased was subsequently seen by ANPs on six more occasions between then and her subsequent admission to hospital and as a result there were multiple opportunities for this error to be spotted and corrected but this did not happen because at those visits there was no consideration being given by the ANPs to the patient's medication regime to ensure that appropriate treatment was being provided. 2. Whilst ANPs could access medication charts if required, this was not being done routinely, principally by virtue of time restraint issues. 3. I am concerned that the absence of proper scrutiny or review of the medication of elderly patients in care homes during each visit presents a risk to life as it can lead to the type of error which occurred in this case not being identified.
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 9th of June 2022 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 Family of the Deceased and to the Chief Coroner. 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	Dated 14th April 2022  Signature Senior Coroner for North Wales (East and Central)