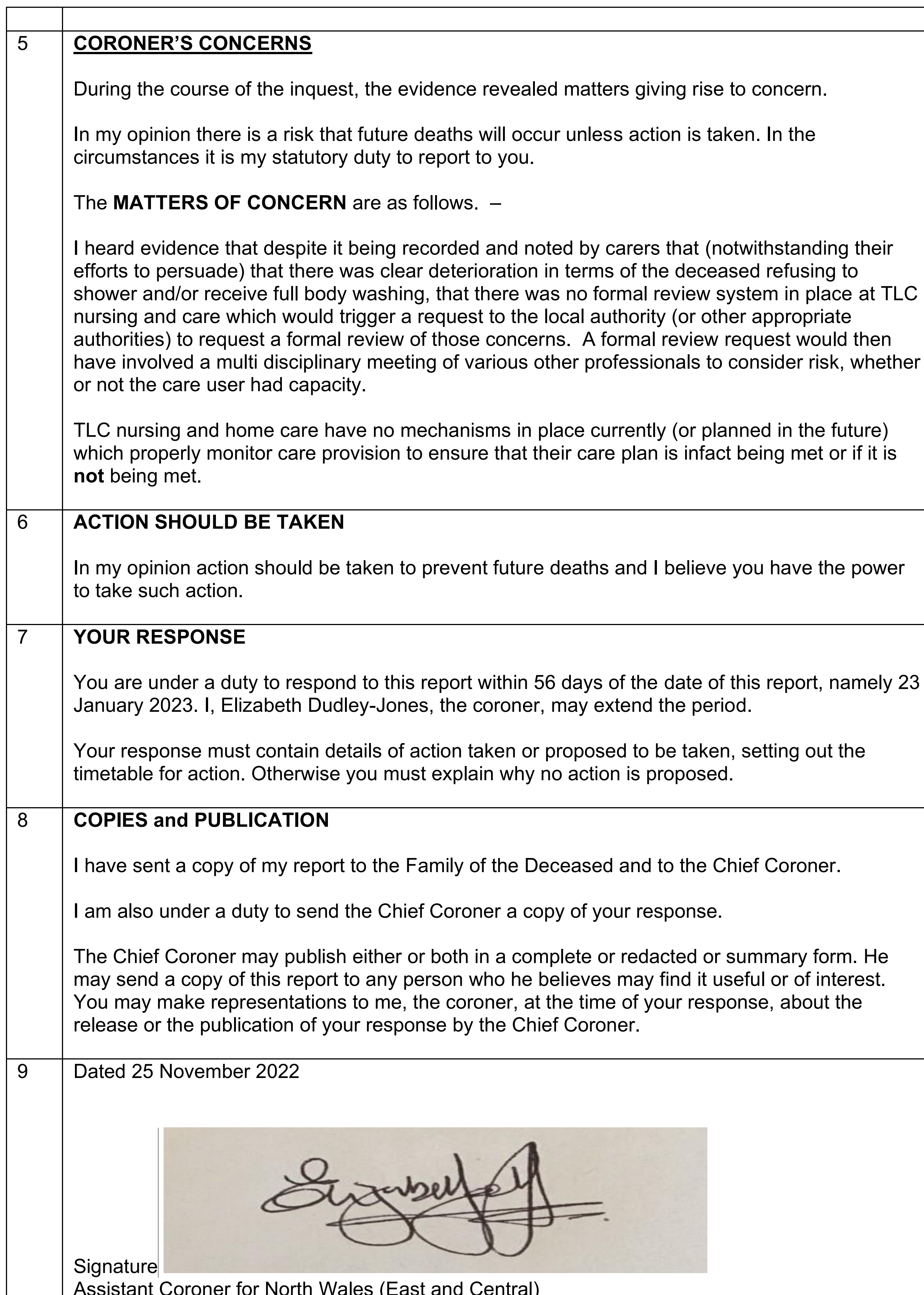
Elizabeth Dudley-Jones
Assistant Coroner for North Wales (East and Central)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** TLC Nursing and Care
1	**CORONER** I am Elizabeth Dudley-Jones Assistant 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 22 November 2022 I commenced an investigation into the death of Ann Daghlain (DOB 12 November 1937 and (DOD 13 February 2021). The investigation concluded at the end of the inquest on 24 November 2022 The conclusion of the inquest was a narrative conclusion as follows : Ann Daghlian came by her death on 13 February 2021 at 12.40 at Wrexham Maelor Hospital from sepsis as a result of a sacral pressure sore, contributed to by metastatic breast cancer. Ann was first diagnosed with metastatic breast cancer in 2017 and she suffered spinal cord compression and as such she also had a permanent catheter. She had lifelong chronic psoriasis. She had a package of care with carers from 2017 and regular visits from District Nurses. At the end of 2020, her health had deteriorated - she had received palliative radiotherapy, suffered weight loss and appetite difficulties. Her mobility was once again affected and she began to decline an upstairs shower. Ann also refused to undertake full body washing, such that it went unnoticed that a pressure sore had developed on her buttock region. On 29 January 2021, a carer noticed a redness to Ann's buttocks and thereafter, her family and District Nurses were informed. District Nurses appropriately attended to the pressure sore and dressing it until 9 February 2021, whereupon it was decided that it had deteriorated to the point of hospital admission. Ann was admitted to Wrexham Maelor Hospital on 9 February 2021, but she deteriorated despite clinical efforts and she died on 13 February 2021.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are as follows : As detailed in 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. – I heard evidence that despite it being recorded and noted by carers that (notwithstanding their efforts to persuade) that there was clear deterioration in terms of the deceased refusing to shower and/or receive full body washing, that there was no formal review system in place at TLC nursing and care which would trigger a request to the local authority (or other appropriate authorities) to request a formal review of those concerns. A formal review request would then have involved a multi disciplinary meeting of various other professionals to consider risk, whether or not the care user had capacity. TLC nursing and home care have no mechanisms in place currently (or planned in the future) which properly monitor care provision to ensure that their care plan is infact being met or if it is **not** being met.
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 23 January 2023. I, Elizabeth Dudley-Jones, 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 25 November 2022  Signature Assistant Coroner for North Wales (East and Central)