ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, Cardiff and Vale UHB** **2. Chief Executive, Abbott Nutrition**
1	**CORONER** I am Rachel Knight, Assistant Coroner, for the South Wales Central Area
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 20th January 2021 I commenced an investigation into the death of Yvonne Dian Rankin, aged 68. The investigation concluded at the end of the inquest on 6th December 2022. The conclusion of the inquest was a narrative. The cause of death was recorded as follows: 1a. Septic Shock 1b. Abdominal wall abscess at and below the PEG site (operated) 1c. Squamous cell carcinoma right tonsil II: Type 2 diabetes
4	**CIRCUMSTANCES OF THE DEATH** Yvonne Rankin was aged 68 when she died at the University Hospital of Wales on 14th January 2021. Yvonne was suffering with throat cancer and undergoing radiotherapy. She had been fitted with a PEG to enable nutrition, medication and fluids to be administered. Despite good care of it, her PEG site became infected with bacteria and a fungal infection which was initially treated and improved. However, an infection returned, and Yvonne quickly developed sepsis. Sadly, despite extensive medical treatment she died.
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 could 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 family and Yvonne were told that they could refer any concerns to various professionals including the Abbott nurse, they did not understand the specific signs of sepsis to watch out for; (2) had family understood the signs of sepsis, it is likely that they would have rung

	999 much sooner; and (3) It may be that patient/carer information cards setting out the common signs of sepsis already exists. Would it be possible to give out such information cards to patients/carers with PEGs and/or those with a known risk of infection who are in the community?
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 7th February 2023. 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 family of Yvonne Rankin and her Abbott nurse, who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**DATE: 13.12.22** **Rachel Knight** **Assistant Coroner** RKnight