Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: [redacted] - Director of Nurse and Health Professional Education, Health Education and Improvement Wales (HEIW))
1	**CORONER** I am **Caroline Saunders,** Senior Coroner for the Area of Gwent
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 5/10/2020 an investigation was opened into the death of Glenys Lillian Phipps The investigation concluded at the end of the inquest on: 8/12/2022 <u>The conclusion of the inquest was recorded as:</u> Death by Accident. <u>The medical cause of death was:</u> 1a Subdural haematoma 1b Fall 2. Advanced Vascular Dementia. Hip Fracture, CVA, Osteoarthritis, hypertension, Pancreatitis, gallstones, poor mobility
4	**CIRCUMSTANCES OF THE DEATH** Glenys Lillian Phipps was admitted to hospital on 3/9/2020 for investigations of abdominal pain. Glenys suffered with dementia and was confused in hospital. There was an inadequate assessment of her risk of falling and no personalised care plan was developed to reduce the risk. Glenys fell twice in hospital. The second fall on 17/9/20

	resulted in a cerebral bleed. Her condition deteriorated thereafter, and Glenys died as a result of the head injury on 21/9/20 at Nevill Hall Hospital.
5	**CORONER'S CONCERNS** During the course of the inquest, 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 that a key component of the policy to minimize the risk of falls is a thorough understanding of the multifactorial risk assessment process (MFRA) Whilst I was informed that all adult nurses were made aware of the risk of falls during their nurse training, they are not trained in the use of the MFRA. It is clear that newly qualified nurses rapidly assume responsibility for the care of a group of patients, often before they can undertake the MFRA training. The senior nurse who gave evidence and presented the internal investigation into the circumstances surrounding Mrs Phipps' death, undertaken by Aneurin Bevan University Health Board, confirmed that it would be beneficial to the safety of patients if MFRA processes were taught to student nurses prior to qualification.
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. <u>I should be grateful if the following information be provided to me:</u> In light of the evidence heard, the steps being taken by the training facilities to ensure that nurses are adequately trained in falls risk management prior to qualification.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely . I, the Coroner, may extend this 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 necessary
8	**COPIES AND PUBLICATION** I have sent a copy of my report to the Chief Coroner and the following Interested Person (s) The family of Glenys Phipps Health Inspectorate Wales.

	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 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: 22 December 2022** Signed  Caroline Saunders **His Majesty's Senior Coroner for the Area of Gwent.**