	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO:
1	**CORONER** I am**, Naomi Rees** Former Assistant 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 an investigation was opened on 22 June 2021 into the death of **Mary Doreen White** The investigation concluded at the end of the inquest on: 5 July 2022 <u>The conclusion of the inquest was recorded as:</u> Accident <u>The medical cause of death was:</u> 1 a Chest Infection b Osteoporotic fracture of right neck of femur (operated) and Chronic Obstructive Pulmonary disease II. Frailty of Old Age
4	**CIRCUMSTANCES OF THE DEATH** Mrs White was a lady of advancing years, who had a number of increasing health concerns. She was admitted into Ysbyty Ystrad Fawr on 5 April 2021. Whilst she was an inpatient she had three falls. The first fall caused superficial head injury, the second fall caused a right fractured neck of femur and the third caused Mrs White to suffer a moderately displaced intertrochanteric fracture of the right proximal femur. Following the third fall she underwent surgery at the Grange University Hospital but when recovering from that surgery her condition deteriorated and she died. Box 3 of the Record of Inquest reads: Mary Doreen White was admitted to hospital in April 2021. She fell in hospital and suffered traumatic injury which required surgery. Whilst recovering she developed a chest infection from which she could not recover. Her condition deteriorated and she died on 9 July 2021 at Ysbyty Ystrad Fawr.
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: -

	Evidence received during the investigation and inquest (and corroborated by the family) demonstrated that nursing staff were trying to manage and care for patients in the very best way that they could. However, they were hampered in their efforts for the following reasons: 1. Despite requesting additional nursing staff, the Bargeod ward was short-staffed when Mrs White fell. There did not appear to be any documented plan or procedure in place for how patients would be safely managed when it was not possible (because of staff shortage) to carry out the level of care for individual patients that they had been assessed as requiring. 2. The ward is L-shaped and the patients on the ward are managed in individual cubicles. Mrs White should have been in view of nursing staff as part of her Level 4 enhanced care ('observation of cohorted patients'). However, it was not possible to provide the observations that Mrs White required because: a. Patients were inside cubicles and therefore out of sight of staff and, b. The ward itself was L-shaped. 3. The Bargoed ward is a stroke ward and one where it is usual to see patients who have a high risk of falls and mobility difficulties. Prior to Covid-19 it was explained that staff would take patients who required the Enhanced Care to the dayroom so that they could be under the required observation. Since Covid-19, this had not been possible. To counteract the logistical difficulties faced by staff in observation of Enhanced Care patients on the ward it was explained that patients are now moved to their cubicle doorway for periods of the day so that they are in sight of nursing staff. This appeared to be ineffective because: a. The particular care needs/wishes of a patient may mean that is not suitable. b. That only accounts for part of the day. 4. To further counteract the difficulties with observing patients on Enhanced Level 4 care it was explained that clip-on alarm sensors were used. There was evidence given that patients are able to simply unclip these sensors, rendering the system ineffective. A Falls Review Panel had noted that Providing Level 4 Enhanced Care on this ward was extremely challenging and that quality care at Level 4 was unachievable in a single room environment. It was noted that the Corporate Nursing Team had reviewed the Enhanced Care Policy in light of the fact it did not fit single room environment, however at the time of the inquest it did not appear from evidence received that a further plan to manage Level 4 patients on this ward had been made and/or communicated to staff.
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. • Confirm whether any investigation and/or steps have or will be taken to address the difficulties encountered with staffing and observation and care of

	Enhanced Level 4 Patients on single unit wards (particularly on Bargoed Ward, where Mrs White was cared for).
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely 01 April 2023. **The Senior Coroner for Gwent (Caroline Saunders)**, 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 Mrs White 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 2 February 2023** Signed:  Naomi Rees **Former Assistant Coroner for the Area of Gwent.**