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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Betsi Cadwaladr University Health Board (BCUHB),
1	**CORONER** I am John 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 23rd of January 2023 an investigation was commenced into the death of Malcolm Ralph Unwin (DOB 15/03/43) who died at Wrexham Maelor Hospital on the 6th of January 2023. The conclusion of the inquest on the 16th of August 2023 was that the death was due to an accident.
4	**CIRCUMSTANCES OF THE DEATH** On the 30th of December 2022 the deceased had unwitnessed fall from bed whilst a patient at the hospital resulting in injuries. The cause of death being 1(a) Head Injury with skull fracture and diffuse axonal injury (b) Mechanical Fall (c) Frailty associated with bladder cancer and prostate cancer.
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. – There was no evidence that the deceased had been assessed for bed rails, whilst in hospital although it is probable that they were in due at the time of his fall. Evidence was given that the bed rail assessment is not currently a part of the Welsh Nursing Care Record which staff access via iPad. In the absence of this being a part of the WNCR I am concerned that this assessment may be missed, and that future death may occur as a result.
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 12th October 2023. I, John Gittins, the Coroner, may extend the period. I would be prepared to accept a joint response from all organisations. 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 17th August 2023  Signature Senior Coroner for North Wales (East and Central)