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: The Chief Executive of Aneurin Bevan University Health Board.
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 19/01/2021, an investigation was opened into the death of Catriona Ellen Martin The investigation concluded at the end of the inquest on 23/11/2023. The conclusion of the inquest was recorded as a narrative conclusion in the following terms: Catriona Ellen Martin was admitted to hospital on 05/12/2020 with autoimmune encephalitis. The treatment plan was not adhered to because Catriona was not provided with adequate nursing care which resulted in a failure to observe her, failure to administer medication and caused her to develop dehydration, acute kidney injury and uncontrolled seizures. This resulted in Catriona's death at the Grange University Hospital, Llanfrechfa on 25/12/2020. Catriona Ellen Martin died from the effects of autoimmune encephalitis contributed to by neglect. The medical cause of death was: 1a) Autoimmune encephalitis
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of Catriona's death are best described in the narrative conclusion. Throughout her admission Catriona required 1:1 nursing care which, apart from a short admission to ITU between 08/12/2020 and 15/12/2020, Catriona did not receive. The nursing staff relied on Catriona's mother to ensure that Catriona received the fluid and medication she required. Catriona's mother continuously advised the

	nursing staff that she was unable to ensure that Catriona was receiving fluid and medication, however no assistance was given, and Catriona went into a fatal decline. I found that Catriona's death would have been prevented if 1:1 nursing care had been provided.
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows: - At the inquest I determined that the level of care that Catriona's mother was expected to provide was unacceptable but was informed that there are no guidelines to establish the level of delegation of nursing duties in such circumstances, and the requirement of the nursing team to not only continue to supervise care but to support and intervene as required.
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. I should be grateful if the following information be provided to me: All guidelines and policies regarding the delegation of nursing responsibilities to family members when these are tasks that the family do not normally provide and for which they have had no training. Note, this is separate to the care provided in hospital by regular community carers or family members who undertake these tasks at home and are cognisant of the patient's normal needs and requirements.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely 29/01/2024. 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 Catriona Martin 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 4/12/2023** Signed: *C Saunders* Caroline Saunders **His Majesty's Senior Coroner for the Area of Gwent.**