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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** BCUHB, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd LL57 2PW.
1	**CORONER** I am John Adrian 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 28th of September 2020 I commenced an investigation into the death of Jennifer Ann Trigger (DOB 27.12.48 DOD 31.1.20). The investigation concluded at the end of the inquest on the 29th of February 2024. The cause of death was recorded as being due to 1(a) Extensive intra-cranial bleed 2. Warfarin Therapy and the conclusion of the inquest was that of natural causes contributed by neglect.
4	**CIRCUMSTANCES OF THE DEATH** On the evening of the 29th of January 2020, the deceased was admitted to the Wrexham Maelor Hospital after becoming unwell. It was established that she had suffered an acute stroke and as she was on warfarin for a pre-existing condition , she was appropriately prescribed beriplex by way of treatment to reduce the risk of an extension of the bleed in her brain. Although this was prescribed at around 20.45 it was not administered until 07.35 the following morning despite it being a time critical treatment. By this time there had been an extension of the bleed with associated oedema and her condition had deteriorated significantly. Despite medical intervention and treatment in intensive care she was verified deceased at 18.30 on the 31st of January 2020
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed the following matter 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 **MATTER OF CONCERN** is as follows. – There was a miscommunication or misunderstanding when a ward nurse bleeped a junior doctor with a view to action being taken in relation to the administration of the beriplex infusion. This resulted in a delay in the doctor attending as she did not prioritise a task which was time critical and the subsequent delays resulted in an unrecoverable deterioration in the patient's condition. Evidence was received in the course of the inquest that the current bleep system did not enable information to be conveyed electronically and that this in turn created a risk of misunderstanding

	as to work requirements and hence impacted upon prioritisation of tasks and therefore potential delays, the effects of which (as in this case) could be catastrophic in terms of patient safety. Evidence was also given that alternative systems existed that had the potential for mitigating or eliminating such risk by way of the electronic transfer of information and requests to doctors.
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 26th of April 2024 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 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 1st March 2024  Signature, Senior Coroner for North Wales (East and Central)