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 12/05/2023, an investigation was opened touching upon the death of: Neil Francis Edwards The investigation concluded at the end of the inquest on 08/03/2024. <u>The conclusion of the inquest was recorded as a narrative conclusion in the following terms:</u> Neil Francis Edwards was admitted to the Grange University Hospital in Llanfrechfa on 12/04/2023 in respiratory failure. He was at a high risk of falling and required 1:1 observation throughout the entirely of his admission. Mr Edwards was transferred to Ysbyty Aneurin Bevan where he suffered a fall on 01/05/2023 and fractured his hip. He was not being observed at the time. Mr Edwards underwent surgery to repair his hip on 03/05/23 at the Grange University Hospital. Postoperatively Mr Edwards suffered a gastrointestinal bleed contributed to by the stress of the fracture and the necessary surgery. He did not have the physiological reserve to withstand the effects of the haemorrhage and he died at Nevill Hall Hospital 09/05/2023. His death was contributed to by neglect. <u>The medical cause of death was:</u> 1a) Upper gastrointestinal bleed 2) Fractured neck of Femur (Operated). Chronic Obstructive Pulmonary disease

4	**CIRCUMSTANCES OF THE DEATH** It was determined that Neil Francis Edwards should have been under 1:1 observation from the time of his admission until at least the time he fell and sustained the hip fracture on 01/05/23. Mr Francis suffered 4 falls whilst in hospital and was not being observed on any of these occasions. The trauma associated with his final fall and the requirement for surgery resulted in a stress-related gastrointestinal haemorrhage and his death.
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows: - The inquest was advised that a Falls Panel had been convened to determine, in part, whether action could have been taken to prevent a fall which had occurred on 23/04/23. I received no evidence that there had been any investigation into the other falls including, importantly, the fall on 01/05/23 that contributed to Mr Edwards' death. The court regularly hears that investigations into the circumstances of in-patient falls is central to minimising the risk going forward. It is of concern that no such investigation was undertaken at this time. Additionally, as there was no investigation, the court was not reassured as to how deaths in similar circumstances might be prevented in the future.
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> Confirmation as to whether it remains the policy of ABUHB to investigate deaths arising from in-patient falls. Confirmation whether, in light of the circumstances described at the inquest, action is being taken to ensure that patients who require 1:1 observation are afforded this level of care in the future.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely 15/05/24. 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 Neil Francis Edwards • 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 20/03/24** Signed:  Caroline Saunders **His Majesty's Senior Coroner for the Area of Gwent.**