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 12/10/2023, an investigation was opened touching upon the death of Kay SIMMONDS The investigation concluded at the end of the inquest on 7/8/2024 The conclusion of the inquest was recorded as Narrative Conclusion: "Kay Simmonds attended the Grange University Hospital in Llanfrechfa on 21/7/2022 with signs of sepsis, arising from an infected central line used for haemodialysis. On 22/7/2022, Kay developed septic shock and should have been admitted to the Intensive Care Unit (ITU). Kay was erroneously transferred to the University Hospital of Wales where there were no ITU beds available. Overwhelmed by sepsis, Kay collapsed and died at the University Hospital of Wales on 22/7/22 at 23:45 hours" The medical cause of death was: 1a) Sepsis 1b) End Stage renal Failure (Treated) 1c) Type 2 Diabetes Mellitus 2. Ischaemic Heart Disease.
4	**CIRCUMSTANCES OF THE DEATH** These are described in the Narrative Conclusion in Box 3.

5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows: - Kay Simmonds was admitted to the Emergency Department of the Grange University Hospital on 21/7/2022. At 14:40 a nurse performed observations and calculated her NEWS score. However this calculation was incorrect. As a result Kay was not referred to a senior medical practitioner in line with the NEWS algorithm. Additionally, the observations were not thereafter performed in line with the NEWS requirements. The miscalculation of NEWS and failure to recognise a deteriorating patient can put lives at risk.
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. At the inquest I heard evidence that, unlike other departments in Aneurin Bevan University Health Board, the Emergency Department is still dependent upon the manual calculation of NEWS observations and relies upon the memory thereafter of nurses to perform observations in a timely fashion. In a busy department this exposes the staff and patients to risks of human error. The evidence I heard was that there is currently no plan to implement the electronic version of the NEWS system in the Emergency Department because it is not compatible with the current computer system. Whilst it is not for the Coroner to determine priorities in resourcing projects , I would bring to your attention that this is not the first failure of the manual NEWS system which has come to light though the inquest process. The clinical staff at this inquest were not aware of this error until it was exposed in court.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely 08 October 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 Kay Simmonds

	• Chief Executive of Cardiff and Vale University Health Board 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 15/8/2024** Signed  Caroline Saunders **His Majesty's Senior Coroner for the Area of Gwent.**