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 14th of June 2024 I commenced an investigation into the death of Margaret Joy Daly (DOB 23.10.32 DOD 10.6.24). The investigation concluded at the end of the inquest on the 24th of October 2024. The cause of death was recorded as being due to 1(a) Traumatic subdural haematoma (b) A fall 2. Delirium and the conclusion of the inquest was that the death was due to an accident.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are that Mrs Daly had been an in-patient at Wrexham Maelor Hospital and as a result of her being assessed as being at significant risk of falling she was on an enhanced level of observation. On the evening of the 1st of June 2024, Mrs Daly was exhibiting signs of anxiety and agitation and a member of nursing staff asked a doctor to review her. As the doctor was too busy to attend the ward, the nurse took Mrs Daly's prescription chart to the doctor on another ward and he prescribed a sedative, namely lorazepam which was administered to her at 22.40 that evening with a further dose being given at 04.30 the following day. Later that morning Mrs Daly had an unwitnessed fall and sustained the injury which resulted in her death. The evidence supports a view that it is probable that she fell as a result of the effects of the sedation.
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. – The clinician who prescribed a sedative, did so, without reference to any of Mrs Daly's notes other than her prescription chart and as a result was unaware of her enhanced falls risk or any other behavioural issues. Whilst I recognise that medication changes may be necessary without the doctor being able to review a patient in person, I am concerned that this may occur without the doctor having access to and considering her full medical records and risk assessments.

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 23rd of December 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 28th October 2024  Signature, Senior Coroner for North Wales (East and Central)