## Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

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| | **REGULATION 28 REPORT TO PREVENT DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1 Chief Executive of Aneurin Bevan University Health Board** |
| **1** | **CORONER**<br><br>I am Caroline Saunders, Senior Coroner for the coroner area of Gwent. |
| **2** | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 02 November 2023 I commenced an investigation into the death of Jean THOMAS aged 85. The investigation concluded at the end of the inquest on 09 October 2024. The conclusion of the inquest was that:<br><br>Accident<br><br>Accident |
| **4** | **CIRCUMSTANCES OF THE DEATH**<br><br>Jean Thomas fell at home on 20/10/23 and fractured her hip. She underwent surgical fixation but developed post-operative sepsis. Against the background of her underlying medical conditions the infection proved overwhelming and Jean died at the Grange University Hospital in Llanfrechfa on 26/10/2023. |
| **5** | **CORONER'S CONCERNS**<br><br>During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.<br><br>The **MATTERS OF CONCERN** are as follows:<br>(brief summary of matters of concern)<br><br>Jean was known to have significant cardiovascular problems and from her admission there were signs this was worsening.<br><br>Her blood pressure was low, which would normally be treated with intravenous fluids, but excess fluids would put more pressure on her heart, and thus she was also treated with a low dose of furosemide.<br><br>The management of Jean's fluid balance was important for the following reasons; she had heart failure, she had chronic renal failure, she had signs of a superimposing acute kidney injury and she was scoring on the NEWS chart from admission, such that the algorithm required the fluid balance to be monitored. Jean had signs of sepsis. |

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| | I find at inquest that Jean's fluid balance was not monitored, which I determined to be a failure in care. It was not monitored by the nursing or the medical staff. Whilst I could not find that knowledge of Jean's fluid balance would have altered the outcome, it is a matter of grave concern that this basic nursing care was ignored, and these important clinical indicators not monitored by the medical staff. |
| **6** | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) have the power to take such action. |
| **7** | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 18 December 2024. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons<br><br>**Health Inspectorate Wales**<br><br>I have also sent it to<br><br>**Family Members Of Jean Thomas**<br><br>who may find it useful or of interest.<br><br>I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it.<br><br>I may also send a copy of your response to any person who I believe may find it useful or of interest.<br><br>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.<br><br>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: 23/10/2024**<br><br>**Caroline Saunders**<br>**Senior Coroner for** |