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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** BCUHB, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd LL57 2PW ("the Health Board"). **2.** Pendine Park Care Organisation, Highfield, Summerhill Road, Wrexham LL11 4YE ("the Nursing Home"
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 1st of July 2024 I commenced an investigation into the death of Patricia Ann Catterall (DOB 3.1.43 DOD 23.6.24). The investigation concluded at the end of the inquest on the 11th of April 2024. The cause of death was recorded as being due to 1(a) Hyperosmolar Hyperglycaemic Syndrome ("HHS") and Sepsis with Pneumonia 2. Frailty of Old Age and Dementia and the conclusion of the inquest was that of a death from natural causes.
4	**CIRCUMSTANCES OF THE DEATH** On the 11th of June 2024 the deceased's care was transferred from the Health Board to the Nursing home following the deceased having spent 207 days in the care of the Health Board at Mold Community Hospital Whilst under the care of the Health Board, the deceased's blood sugar levels were checked three times per day, however once she became resident at Pendine, they were only checked once a day. During the period between the 11th and the 19th of June 2024, the deceased's condition deteriorated and on the 19th of June she was admitted to the Maelor Hospital Wrexham where she was diagnosed as having HHS and sepsis. Her condition and co-morbidities were such that it would have been inappropriate to aggressively treat these conditions and she passed away a few days later.
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. – That the process of assessment by the Nursing Home prior to the transfer of care to them was not sufficiently robust so as to ensure that all relevant information required for the safe care of a patient had been received and assessed prior to the patient being received into their care. Evidence was received that in the majority of cases (post Covid) there are no face to face assessments prior to patient transfer and that the assessment is therefore dependent on the documentation supplied to the Nursing Home by the Health Board which in some cases may result in not all relevant information being provided. In this instance evidence was given that the Nursing Home did not know that the deceased's blood sugar levels were monitored three times per days whilst in the care of Health Board.
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 6th of June 2025 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 11th April 2025 Signature  Senior Coroner for North Wales (East and Central)