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: <u>The Chief Executive of Aneurin Bevan University Health Board</u>
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 28/2/2024 an investigation was opened touching upon the death of Marina Lorraine Waldron The investigation concluded at the end of the inquest on 9/5/2025 <u>The conclusion of the inquest was recorded as</u> A Narrative Conclusion in the following terms: "Marina Lorraine Waldron died from the effects of aortic valve disease contributed to by the side effects of treatment for ischaemic heart disease on 15/2/2024 at the Grange University hospital in Llanfrechfa. Her death was also contributed to by malnutrition. <u>The medical cause of death was:</u> 1a) Lower Gastro-intestinal bleeding from angiodysplasia 1b) Aortic Stenosis 2. Ischaemic heart disease with recent stent placement. Malnutrition.
4	**CIRCUMSTANCES OF THE DEATH** Marina Waldron was admitted to hospital on 17/12/2023 with evidence of gastrointestinal bleeding. I will not describe in detail the investigations performed or the treatment she received thereafter. I found that this difficult situation was investigated and managed appropriately. Despite receiving all appropriate treatment

	the gastrointestinal bleeding, caused by angiodysplasia, an uncommon complication of aortic stenosis, proved overwhelming and MW died on 15/2/2024.
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows: - During the 8 ½ weeks of MW's hospital admission, her nutritional needs were poorly considered or managed. Examples of this include: 1. An ongoing failure to heed the family's concerns that from admission to hospital, MW was not eating or drinking adequately 2. A failure to formally monitor MW's dietary intake 3. A failure to respond to a low Albumin level which is a sign of malnutrition 4. Dietary advice and parenteral feeding were not properly considered until 29/1/2024 (6 weeks after admission) The medical staff who gave evidence agreed that malnutrition contributed to MW's death.
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. Whilst the cause of the malnutrition was likely to be multi-factorial, nonetheless basic steps to address the situation were not taken. I am concerned that poor attention to the basic nutritional needs could give rise to future deaths, especially in the elderly and those with depleted physiological reserves.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely 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 Marina Lorraine Waldron 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 20/5/2025** Signed  Caroline Saunders **His Majesty's Senior Coroner for Gwent.**