GRAEME HUGHES

HIS MAJESTY'S SENIOR CORONER

SOUTH WALES CENTRAL CORONER AREA

CORONER'S OFFICE
THE OLD COURTHOUSE
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ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], **Principal Manager For Adult Service Provision, MTCBC**
1	**CORONER** I am Graeme D Hughes, H M Senior Coroner for the area of South Wales 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 20 March 2022 I commenced an investigation into the death of Valerie HILL . The investigation concluded at the end of the inquest 29/05/2025. The conclusion of the inquest jury was a Narrative. The Cause of Valerie's death was found to be: **1a Pnuemonia** **1b Fall leading to periprosthetic fracture of femur** **1c** **II Chronic obstructive pulmonary disease (COPD), frailty of old age**
4	**CIRCUMSTANCES OF THE DEATH**

	Valerie died by pneumonia and a fall leading to a periprosthetic fracture of femur. COPD and frailty of old age were contributing factors. Valerie died on 11 March 2022 at Royal Glamorgan Hospital, following a fall at Ty Bargoed Care Home on 7 March 2022. She endured a long lie on the floor of over 14 hours whilst waiting for an ambulance to attend. It is possible that this long lie exacerbated known medical conditions. It is probable that the lack of risk assessments completed and referrals for Valerie during her time at Ty Bargoed meant appropriate precautions were not taken to prevent further falls. It is possible, due to long ambulance handover times across Cwm Taf Morgannwg Health Board and inadequate systems in place to effectively manage patient flow that this contributed to the long lie.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters 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 **MATTERS OF CONCERN** are as follows. (1) The identification of, and reduction of falls risks was a central feature of the evidence in the inquest. WAST, in particular had highlighted that falls in care/nursing homes have contributed significantly to the volume of activity in the community, having a *domino* effect/impact on delayed hospital handovers. (2) The material provided at, and post Inquest is absent in evidencing that staff at Ty Bargoed receive any specific, relevant, or effective training in respect of the identification & documenting of falls risks to residents, and the mitigation that can be put in place to reduce those risks. In particular, how the assessments ought to be approached and completed. The material filed, largely relates to employee safety in being able to move and handle residents appropriately. That, I understand is not the aim of the All-Wales NHS Patient Moving and Handling Assessment Documents I was taken to at the Inquest. (3) the material filed with me focuses upon how to move a fallen person/their management post fall, not the identification /assessment/documentation of risk in order to prevent/mitigate the happening of such events. (4) The exhibits to your statement at KL 1 page 58 appear to suggest that the risk assessment forms ought to be completed/counter-signed by a Registered Healthcare Professional. I received no evidence that such a practice was/is in operation at Ty Bargoed (5) Your Exhibit KL1 at page 27 references regard being had to Falls Prevention Strategy or Policy – I have received no evidence that MTCBC have such available and in place to inform Care Home's and their staff in preparation for the completion of a resident's falls risk assessment (6) Whilst I am reassured to an extent in relation to the management and retention of incident & risk assessment documentation created in Ty Bargoed moving forwards, I am unclear as to what action, if any, MTCBC's Health and Safety Unit take upon receipt of

	falls notifications (as described in [redacted]'s evidence) and what, if any, analysis/assessment/communication is undertaken in respect of the same with a view to supplementing the ongoing falls risk assessment and collateral mitigating measures.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 8th August. Only 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 all Interested Persons & Care Inspectorate Wales who may find it useful or of interest. 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	13 June 2025 **SIGNED:**  Senior Coroner for South Wales Central Coroner Area