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CYMRU
NHS
WALES

Bwrdd Iechyd
Addysgu Powys
Powys Teaching
Health Board

13 October 2025

Private and Confidential

Mr Andrew Morse

His Majesty's Coroner

Dear Mr Morse

Re: Response to Regulation 28, following the death of Mr Edward Funnell

This response is sent in accordance with your direction dated 2 September 2025 that a response from Powys Teaching Health Board (PTHB) is provided to the Regulation 28 Prevention of Future Deaths Report, in the inquest touching the death of Edward Funnell. This response seeks to explain the actions to be taken to address the matters of concern and recommendations as identified by the learned Coroner.

During the course of the inquest the evidence revealed matters that give rise to concern, the matters of concern are outlined as follows.

- a) There was a lack of appreciation of the need for the deceased to see a podiatrist as recommended by a Tissue Viability Nurse. The referral was not followed up or actioned.
- b) There was an identifiable lack of knowledge on the part of the nursing staff to understand the reason for referral to a podiatrist and the possible interventions a podiatrist could undertake, in respect of pressure wound damage, particularly in patients with circulatory problems.
- c) There was an identifiable lack of knowledge on the importance of following the recommendations of the Tissue Viability Nurse in respect of the type of dressings to be administered and the importance of ensuring such steps were followed, as opposed to using an alternative and, on the evidence, an inappropriate dressing.

Cont....

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A response to each matter is provided below which will include actions taken or action proposed to be taken within specific timescales.

a) There was a lack of appreciation of the need for the deceased to see a podiatrist as recommended by a Tissue Viability Nurse. The referral was not followed up or actioned.

Response

- We recognise that there was a delay of 27 days between the referral to Podiatry and the initial appointment. During that delay, no follow up had occurred to express the urgency of the referral.

Action

- The referral pathway to podiatry is being updated to ensure that urgent referrals are responded to within 5 working days, if this is not possible an escalation framework is in place to provide additional support.
- The Tissue Viability team have updated their referral process (Appendix A) this has been shared widely with clinical teams, which underlines the requirement for foot ulceration to be referred to Podiatry without delay. (Implemented September 2025)
- Implementation of a Vascular limb check observation chart (Appendix B) (Implemented September 2025)
- Learning identified within this Regulation 28 will be shared with all ward leaders on 14 October 2025.
- 7minute briefing to be shared with all staff in the health board during October 2025.
- Matters of the Regulation 28 and associated learning will be shared at the Patient Experience, Quality & Safety Committee on 26 October 2025.

b) There was an identifiable lack of knowledge on the part of the nursing staff to understand the reason for referral to a podiatrist and the possible interventions a podiatrist could undertake, in respect of pressure wound damage, particularly in patients with circulatory problems.

Action

- Lead podiatrist to attend all wards to ensure the teams are aware of the scope and breadth of the role of the podiatrist.
- Lead podiatrist to attend ward leaders meeting on 14 October 2025 to ensure detailed scope and provision of service is understood.
- All pressure ulcers are monitored through All Wales Datix system and presented through pressure ulcer scrutiny group. (Completed)

c) There was an identifiable lack of knowledge on the importance of following the recommendations of the Tissue Viability Nurse in respect of the type of dressings to be administered and the importance of ensuring such steps were followed, as opposed to using an alternative and, on the evidence, an inappropriate dressing.

Cont.....

Action

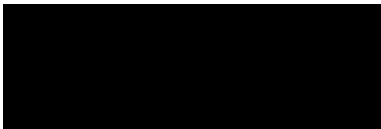
- Tissue Viability Specialist Nurse (TVN) to provide additional training to ward teams regarding the use and access to dressings.
- Ensure all staff attend training provided by TVN's which addresses elements of assessment, escalation and dressing management.

Monitoring of these actions will be undertaken by the Community Service Group Quality Meetings, supporting action plan is included within Appendix C.

I hope you can take assurance that the matters outlined within the Regulation 28 have been taken seriously and all associated actions will be undertaken in a timely manner.

Should you require further clarity regarding the actions and attached action plan please do not hesitate to contact my office.

Yours sincerely

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Chief Executive Officer

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