

GRAEME HUGHES

HIS MAJESTY'S
SENIOR CORONER

SOUTH WALES CENTRAL
CORONER AREA



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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: The Chief Executive of Powys Teaching Hospital Board
1	CORONER I am Andrew Morse, HMC for the Coroner 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 10 May 2023 I commenced an investigation into the death of Edward John FUNNELL. The investigation concluded at the end of the inquest 10/07/2025. The conclusion of the

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	<p>inquest was Natural Causes.</p> <p>1a Ischaemic left foot</p> <p>1b Peripheral Vascular Disease</p> <p>1c</p> <p>II Congestive Cardiac Failure, Chronic Kidney Disease, Ischaemic Heart Disease, Atrial Fibrillation</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>These were recorded as :-</p> <p>Mr Edward John Funnell died on 29th April 2023 at Ystradgynlais Community Hospital. Mr Funnell was admitted to Hereford Hospital on 16th December 2022 for an orthopaedic procedure. During his time at Hereford Hospital he developed a pressure ulcer on his left heel. Mr Funnell was not fit to be discharged home. He was transferred to Llanidloes War Memorial Hospital on 11th January 2023 until admission to Bronglais Hospital and transfer onwards to Morriston Hospital on 19th February 2023. During his time at Llanidloes the pressure ulcer worsened, and he developed an ischaemic left leg. On admission to Morriston Hospital he decided against surgery to amputate his ischaemic left leg and received palliative care at Ystradgynlais Hospital from 24th February 2023 until his death. On balance it cannot be said that missed opportunities to treat and escalate the care of the worsening heel ulcer and signs of ischaemia in the left leg contributed to his death.</p> <p>A finding of natural causes was made. During the course of the inquest extensive evidence was heard in respect of the wound dressings and interventions of nursing and Tissue Viability specialists during the deceased's time at Bronglais Hospital.</p>
5	<p><u>CORONER'S CONCERNS</u></p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows.</p> <ol style="list-style-type: none"> 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. 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

	<p>podiatrist could undertake in respect of pressure wound damage, particularly in patients with circulatory problems.</p> <p>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.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>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.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 28th October 2025. I, the Coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to family who may find it useful or of interest.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>The Chief Coroner may publish either or both in a complete or redacted or summary form. She may send a copy of this report to any person who she 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.</p>
	<p>2 September 2025</p> <p>SIGNED:</p> 

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	HMC, South Wales Central Coroner Area

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