**GRAEME HUGHES**

**HIS MAJESTY'S SENIOR CORONER**

**SOUTH WALES CENTRAL CORONER AREA**

**CORONER'S OFFICE**
**THE OLD COURTHOUSE**
**COURTHOUSE STREET**
**PONTYPRIDD**
**CF37 1JW**

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**ANNEX A**

**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)**

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

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>The Minister for Health and Social Care in Wales |
| 1 | **CORONER**<br><br>I am **Gavin Knox HM Coroner**, for the coroner area of South Wales Central. |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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** |

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| | On 6 June 2022 I commenced an investigation into the death of Pamela SINGH. The investigation concluded at the end of the inquest on 18 September 2025. The conclusion of the inquest was Natural Causes.<br><br>**1a Bronchopneumonia**<br><br>**1b**<br><br>**1c**<br><br>**II** |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>These were recorded as :-<br><br>Pamela Singh died of pneumonia, the signs and symptoms of which had progressed over the course of 3 days. These signs and symptoms were difficult for family and professional care staff to identify and attribute to a potential illness. As a consequence no contact was made with a medical professional until after she went into cardiac arrest. She died on 29 May 2022 at 14 Taymuir Road Splott Cardiff. If she had received medical attention at hospital before she went into cardiac arrest it is likely her death would have been avoided. |
| 5 | **<u>CORONER'S CONCERNS</u>**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows.<br><br>(1) The deceased had a learning disability and died of a community acquired pneumonia, the death being avoidable if there had been earlier recognition of an acute deterioration in her health;<br><br>(2) The evidence heard from a Learning Disability Psychiatrist and expert in Critical Care was that people with a Learning Disability generally have a significantly increased mortality risk;<br><br>(3) The most common cause of avoidable deaths in people with a Learning Disability is pneumonia; |



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| | (4) Delays in recognising, escalating and responding to an acute deterioration is a significant factor in avoidable deaths of people with a Learning Disabilities;<br><br>(5) Family and professional care staff did not have any specific practice tool to help them recognise, escalate and ensure a response to concerns about signs of a potential acute deterioration;<br><br>(6) Neither the GP, Social Worker, or commissioned care provider were familiar with any such tool being used in Wales notwithstanding a recommendation in The Learning Disabilities Mortality Review (LeDeR) Programme Annual Report 2019 to 'Adapt (and then adopt) the National Early Warning Score 2 regionally, such as the Restore2TM in Wessex, to ensure it captures baseline and soft signs of acute deterioration in physical health for people with learning disabilities' |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 18 November 2025. I, the Coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the following who may find it useful or of interest:<br><br>Family of Pamela Singh<br><br>Director of Adult Social Services, Cardiff Council<br><br>Chief Executive Swansea Bay University Local Health Board<br><br>Health Education and Improvement Wales |



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| | ADSS Cymru<br><br>Chief Executive NHS Wales<br><br>Care Inspectorate Wales<br><br>Social Care Wales<br><br>IOS Care Limited<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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. |
| 9 | 18 September 2025<br><br>**SIGNED:**<br><br>  <br>Gavin Knox HM Coroner for South Wales Central Coroner Area |