Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Chief Executive Of Aneurin Bevan University Health Board**
1	**CORONER** I am Caroline SAUNDERS, Senior Coroner for the coroner 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 07 April 2025 I commenced an investigation into the death of Phillip Lawrence HOGGARTH aged 87. The investigation concluded at the end of the inquest on 10 December 2025. The conclusion of the inquest was recorded as: Natural Causes The medical cause of death was: 1a) Myocardial Infarction and Pulmonary Oedema 2) Valvular Heart disease, Left Total Hip Replacement, Hypertension, Anaemia
4	**CIRCUMSTANCES OF THE DEATH** PH was admitted to the Grange University Hospital in Llanfrechfa for a Total hip Replacement, which was successfully performed on 18/3/2025. Post-operatively he deteriorated and suffered a myocardial infarction which resulted in his death on 25/3/2025. PH suffered from chronic iron-deficiency anaemia. The anaesthetists determined that he should have an iron transfusion before his operation. This took place 7 days prior to his admission to hospital. In evidence the inquest was informed that the infusion should have taken place "some weeks" prior to the operation to be effective. The exact number of weeks was unclear, but I was informed that 7 days was not sufficient time for the iron to have any effect. I also heard that there was no apparent consensus between clinicians as to when the infusion should be given, and a lack of communication in this regard may have compounded the problem. Moreover, in this case, the deceased resided in Powys and the iron transfusion (and hence the operation) had previously been postponed as there was a disagreement over which health board should fund the iron infusion.
5	**CORONER'S CONCERNS**

	During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) The deceased died from a heart attack and I did not determine that any omission in the administration of the iron had more than minimally contributed to his death . However the lack of a consistent approach to pre-operative management and administration of iron to a chronically anaemic patient could put patients' lives at risk in the future. Kindly address the issues raised, namely: 1. Whether there are clinical guidelines which determine the pre-operative administration of iron therapy. 2. Whether there is a process which supports these guidelines 3. Whether there is an agreement between Health Boards in these circumstances regard funding to prevent potentially damaging delays in surgery.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 February 10, 2026. 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 the Chief Coroner and to the following Interested Persons **Family Members And Next Of Kin** I have also sent it to **N/A** who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	**Dated: 16/12/2025**

[redacted]

Caroline SAUNDERS
Senior Coroner for
Gwent