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** **2 Chief Executive Of Welsh Ambulance Service Nhs Trust (Wast)**
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 16 January 2025 I commenced an investigation into the death of Della Bridget CALVEY aged 78. The investigation concluded at the end of the inquest on 27 January 2026. Della Bridget Calvey died at home on 16/1/2025 from the effects of overwhelming sepsis caused by a urinary tract infection. The conclusion of the inquest was recorded as: Natural Causes The medical cause of death was: I(a) Adrenal insufficiency due to haemorrhage (b) Sepsis (c) Bronchopneumonia (d) Acute Pyelonephritis II COPD, Cor Pulmonale
4	**CIRCUMSTANCES OF THE DEATH** On Christmas day 2024, DC started to experience back pain which was thought to be the early signs of a Urinary Tract infection. This was eventually diagnosed after a positive urine sample was received on 7/1/25 and DC was started on antibiotics. However, by this time her condition had deteriorated, and she had started to show signs of confusion, and she was not taking an adequate diet. On 10/1/2025 DC's condition worsened and she collapsed. He daughter called for an ambulance and paramedics attended at 1313 hours. On examination the paramedics determined that DC had a raised NEWS score, had non-resolving infection and was dehydrated. Her condition was considerably below her baseline. She was now unsafe to be left alone and her new incontinence had increased her risk of falling; indeed she had already fallen twice, on one occasion resulting a minor injury to her nose.

	Her NEWS score was 5, although both the paramedic (an employee of WAST) and the staff at the FLO centre (employees of ABUHB) considered that it could be safely reduced to 3 on the basis that she had Chronic Obstructive Pulmonary Disease. There were no baseline oxygen saturations known and the court heard there may have been other reasons for her raised NEWS, for example potentially early signs of a chest infection. Had the NEWS score remained at 5, admission to an acute hospital would have been mandated (as opposed to the local general hospital). As it was the inquest concluded that DC was persuaded against hospital admission altogether and to consult her GP. DC died from the effects of urosepsis 6 days later. The inquest determined that Della should have been to hospital but given the nature and severity of her infection could not determine on balance that her death would have been prevented.
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 totality of the evidence indicated that it was not unusual for NEWS scores to be downgraded if a patient had COPD, even when their baseline saturations were not known. The rationale being "COPD sufferers often have lower oxygen saturation levels". Whilst this may be true, applying this to all COPD sufferers, I consider to be an unsafe practice. 1. Confirmation whether downgrading NEWS scores in the circumstances described is acceptable practice (please note that support for this position was provided by the Clinical Lead who has a training remit) 2. What action will be taken to ensure that more robust approach to clinical assessments will take place in the future.
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 April 02, 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

	Health Inspectorate Wales 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: 05/02/2026** [redacted] **Caroline SAUNDERS** **Senior Coroner for** **Gwent**