RESPONSE TO A REPORT TO PREVENT FUTURE DEATHS
REGULATION 29 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

THIS RESPONSE IS BEING SENT TO:

The Senior Coroner, Caroline Saunders for the Coroner Area Gwent in response to a '**REPORT TO PREVENT FUTURE DEATH REGULATION 28'** following an investigation into the death of **Brynley John HURFORD**.

1.	**RESPONDENT** In line with our duty under Regulation 29 of the Coroners (Investigations) Regulations 2013, **Aneurin Bevan University Health Board** provides this response within 56 days (plus any extension granted) of the date of the Report to Prevent Future Deaths.
2.	**DATE OF RESPONSE** **23 October 2026**
3.	**CONFIRMATION OF CORONER'S MATTERS OF CONCERN** The **MATTERS OF CONCERN** were identified in the report are as follows: From 1849 hours, when Brynley's NEWS was 6, the NEWS algorithm dictated that his observations should have been repeated every 30 minutes. His NEWS continued to rise to 12 but were not repeated in line with the algorithm. There was over an hour between each set of observations. It was suggested at the inquest that this could have been due to staff pressures. However, I determined that delays in observations in such an obviously unwell patient, when the diagnosis was unknown was a gross failure in care. However, I also determined that in this instance more regular observations would not have altered the outcome. I am concerned that failing to adhere to this national observation policy may put future lives at risk.
4.	**DETAILS OF ACTION TAKEN,** how has the concern been addressed. [If no action is proposed please explain why here]. *Please note that any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.* The Health Board acknowledges the Coroner's concern regarding non-

compliance with the required NEWS observation frequency requirements in this case. Whilst the Coroner concluded that more frequent observations would not have altered the outcome, the Health Board accepts that observations were not undertaken in accordance with the NEWS escalation algorithm and recognises the importance of ensuring compliance with national standards for the monitoring and escalation of deteriorating patients.

Recognition and response to the deteriorating patient has been a strategic priority for the Health Board and is supported through an established Deteriorating Patient Programme encompassing NEWS2 implementation, staff education, escalation processes, audit and governance arrangements.

Actions Taken – Acute Medical Unit (AMU)

The following actions and controls are in place within AMU:

- Implementation of NEWS2 and improved visibility of NEWS2 scores to support shared nursing and multidisciplinary oversight.
- NEWS2 was rolled out to all staff on the AMU in September 2025 and following this compliance was at 97%.
- NEWS2 education and training has been reinforced for clinical staff, including the required frequency of observations and escalation of deterioration.
- Incorporation of NEWS2 checks into the Nurse in Charge checklist.
- A dedicated Practice Educator supports staff education, competency and practice development, including targeted support where additional learning needs are identified.
- NEWS2 monitoring and escalation requirements form part of local induction arrangements for registered nurses and healthcare support workers.
- The Nurse in Charge has explicit responsibility for oversight of NEWS scores across the unit, supported by the Nurse in Charge checklist, to identify patients requiring increased observation frequency or escalation.
- A structured escalation process is in place to support documentation of the NEWS score, action taken and the clinician to whom concerns have been escalated.
- Deteriorating patients are identified through established operational safety processes, providing an additional opportunity to confirm that appropriate monitoring and escalation are taking place.
- The registered nurse involved in this case was provided with appropriate professional and managerial support and learning following the incident.
- Learning-from-incidents study days for AMU staff.

These measures are intended to strengthen both individual practice and the systems supporting the timely recognition, monitoring and escalation of

	deteriorating patients. **Audit and Assurance** Compliance with NEWS2 observation frequency is being monitored through a combination of Ward Accreditation, Corporate Clinical Audit, targeted case-note review and CareFlow Vitals data. The deteriorating patient audit has now been incorporated into the Ward Accreditation Programme and provides assurance beyond compliance with NEWS2 scoring alone. The audit reviews whether physiological observations are complete and undertaken at the required frequency, but also examines whether deterioration is recognised and appropriately escalated, whether a timely clinical review occurs, the escalation pathway used, whether a clear management plan is documented, and any identified delays in clinical review or treatment. It additionally assesses sepsis screening and response. Findings from the Ward Accreditation Programme are due to be reviewed in December 2026 to identify good practice, variation and areas requiring further improvement. In addition, deteriorating patient audit forms part of the Health Board's 2026/27 Corporate Clinical Audit Plan. This will complement and dovetail with the Ward Accreditation findings through case-note reviews and targeted deep dives, enabling more detailed examination of compliance with observation frequency, recognition of deterioration, escalation and clinical response. As part of this approach, cases referred by the Resuscitation Group will also be included where the Resuscitation Team has attended a patient following a 2222 call and identified concerns relating to deterioration. These cases will provide an additional opportunity for targeted case-note review and deep dive into: • recognition of deterioration; • whether observations were repeated at the required frequency; • the timeliness and route of escalation; • the timeliness and adequacy of the clinical response; and • any recurring contributory factors, learning or good practice. Learning, themes and trends identified through these reviews will feed into the wider Deteriorating Patient Programme. The Health Board is also strengthening its assurance through the use of CareFlow Vitals data. This enables analysis of the frequency and timeliness of recorded observations across clinical areas and supports assessment of

	whether observations are being undertaken at the intervals required by the patient's NEWS2 score and Health Board policy. CareFlow Vitals data will not be considered in isolation. It will be triangulated with clinical records, Ward Accreditation, Corporate Clinical Audit and targeted case-note review to understand whether the frequency of observations, escalation and clinical response were appropriate for the individual patient. Together, these arrangements provide complementary sources of assurance and enable the Health Board to identify good practice, variation, learning, themes and trends, monitor improvement over time and target further action where required.
5.	**DETAILS OF FURTHER ACTION PROPOSED** *Please note that any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.* The Deteriorating Patient Group (DPG) will oversee and triangulate intelligence from: • Ward Accreditation findings; • Corporate Clinical Audit; • case-note reviews and targeted deep dives; • Resuscitation Group referrals following 2222 calls; • CareFlow Vitals data; • patient safety incidents involving deterioration; • mortality and other relevant clinical learning; and • other available sources of quality and safety intelligence. This thematic approach will enable the Health Board to identify learning, themes and trends relating to observation frequency, recognition of deterioration, escalation and clinical response, rather than relying on a single source of assurance. Subsequent reporting cycles will allow findings to be compared over time, including: • compliance with the observation frequency required for each NEWS2 category; • completion of repeat and subsequent observations within the required timescales; • timeliness of escalation and clinical review; • variation between wards, services and sites; • recurring themes and contributory factors;

	• implementation of agreed improvement actions; and • whether improvement is maintained through follow-up review or re-audit. Where gaps are identified, these will inform quality improvement plans, with actions implemented and monitored to demonstrate whether improvement has been achieved and sustained. The Deteriorating Patient Group will use this triangulated intelligence to inform the ongoing Deteriorating Patient Programme and determine whether further organisation-wide or targeted improvement action is required. Areas of non-compliance, emerging themes or unresolved risks will be reported and escalated through the Quality Management Group (QMG), providing organisational oversight and assurance that risks relating to the recognition, monitoring and escalation of deteriorating patients are being identified and addressed. These arrangements provide the Health Board with a strengthened framework for monitoring compliance with NEWS2 observation frequency and, importantly, for identifying where further improvement is required. The Health Board will use Ward Accreditation, Corporate Clinical Audit, case-note review, 2222 case review and CareFlow Vitals data to demonstrate whether the actions taken are resulting in sustained improvement in compliance, rather than relying solely on assurance that processes have been introduced.
6.	**SIGNATURE**   **Prif Weithredwr | Chief Executive**