REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 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).

1.	**CORONER** I am Caroline SAUNDERS, Senior Coroner, for the coroner area of Gwent.
2.	**DATE OF REPORT** 11 September 2026
3.	**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.
4.	**THIS REPORT IS BEING SENT TO** 1. Chief Executive of ANEURIN BEVAN UNIVERSITY HEALTH BOARD You are under a duty to respond to this report within 56 days of the date of this report, namely by November 06, 2026. I, the coroner, may extend the period if an appropriate application is made.
5.	**YOUR RESPONSE** 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note 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 names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
6.	**SUMMARY OF CORONER'S CONCERN** The inquest established that there was a failure to follow the national

	guidelines governing the observations to be undertaken on seriously unwell patients (NEWS algorithm) I am concerned that failing to adhere to this national observation policy may put future lives at risk
7.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
8.	**INVESTIGATION AND INQUEST** On 07 November 2025 I commenced an investigation into the death of Brynley John HURFORD aged 78. The investigation concluded at the end of the inquest on 25 August 2026. The conclusion of the inquest was recorded as: Natural Causes The medical cause of death was: I(a) Perforated Oesophagus (b) Excessive Vomiting (c) Constipation and Gastroenteritis The conclusion of the inquest was that: Brynley John Hurford died on 30/10/2025 at the Grange University Hospital in Llanfrechfa from the effects of a perforated oesophagus caused by excessive vomiting.
9.	**CIRCUMSTANCES OF DEATH** On 28/10/2025 Brynley John Hurford was admitted to the Grange University Hospital in Llanfrechfa with a two day history of excessive vomiting. His observations, blood tests and x-rays were normal and on balance it was determined that Brynley was suffering from constipation contributed to by gastroenteritis. Steps were taken to rehydrate Brynley and on 29/10/2025 he was medically fit for discharge. At 1849 hours on 29/10/25, Brynley's condition deteriorated and his NEWS score was 6. The NEWS continued to be elevated for the rest of the night. Brynley continued to deteriorate and died at 0228 hours on 30/10/2025. A postmortem examination concluded that Brynley had sustained a perforated oesophagus which on balance was due to excessive vomiting. This was a rare and unpredictable event and, in the circumstances, unforeseeable.

10.	**CORONER'S CONCERNS** During the course of the inquest I heard evidence 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: 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
11.	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: • Family members and NOK of deceased I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
12.	**SIGNATURE** [redacted] **Caroline SAUNDERS** **Senior Coroner for** **Gwent**