REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Abbeydale Residential Home, Princes Drive, Colwyn BayRoad**
1	**CORONER** I am JOHN ADRIAN GITTINS, senior coroner, for the coroner area of North Wales (East and Central)]
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 the 4th of December 2012 I commenced an investigation into the death of Annie Ceinwen Jones (DOB 11.11.14, DOD 2.12.12). The investigation concluded at the end of the inquest on the 25th of September 2013 conducted by Assistant Coroner Nicola Jones. The conclusion of the inquest was Natural Causes and the medical cause of death was 1(a) Bronchopneumonia, Vulvulus of Sigmoid Colon with Infarction and Intestinal Obstruction.
4	**CIRCUMSTANCES OF THE DEATH** The Deceased had been admitted to Ysbyty Glan Clwyd on the 1st of December 2012 feeling very poorly and with extensive bruising sustained in a fall from a "stand aid" used to assist her with her toileting needs. An autopsy was undertaken and the above medical cause of death was established.
5	**<u>CORONER'S CONCERNS</u>** During the course of the investigation it became apparent that Mrs Jones had sustained severe bruising to her upper body following the fall referred in paragraph 4 and that she should never have been placed in this "stand aid" which required her to some extent weight bearing. Mrs Jones had not been weigh bearing for over three years. The **MATTERS OF CONCERN** are as follows :- 1. An inadequate assessment of the mobility of Mrs Jones was made 2. The stand aid was unsafe for use with Mrs Jones 3. Not all staff were aware of the limitations of Mrs Jones with regard to her mobility 4. Not all staff were able to operate the stand safely.

	Whilst the incident did not contribute to this death I feel it is necessary to bring this to your attention due to the fragile and vulnerable nature of other patients cared for at the home for whom an injury in these circumstances could result in death.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisations 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 15th January 2014 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 – [redacted] (grandson of the Deceased), Conwy County Council Social Services I am also under a duty to send the Chief Coroner a copy of your response. 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	**[DATE] 20th November 2013** **[SIGNED BY CORONER]**