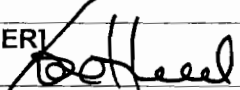


REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <ol style="list-style-type: none"> 1. ABMU Health Board, One Talbot Gateway, Baglan Energy Park, Baglan, Port Talbot, SA12 7BR 2. [REDACTED] The Monkstone House Care Home, 1 Locks Common, Porthcawl, Bridgend CF36 3HU 3. [REDACTED] The Grove Medical Centre, Uplands Terrace, Swansea
1	<p>CORONER</p> <p>I am Louise Hunt, senior coroner, for the coroner area of Powys, Bridgend and Glamorgan Valleys</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 10th May 2013 I commenced an investigation into the death of Terrance O'Connell, aged 70. The investigation concluded at the end of the inquest on 22 August 2013. The conclusion of the inquest was that he died from</p> <ol style="list-style-type: none"> 1a. Right Coronary Artery Thrombus 1b. Sepsis and dehydration 1c. Urinary tract infection <p>The conclusion reached was: the deceased died from a urinary tract infection which went undiagnosed and untreated before his admission to hospital on the 5th May 2013, his condition was contributed to by neglect.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>On the 22nd April Mr O'Connell was admitted to Monkstone Care home for a 2 week respite period whilst his principal carer, his daughter, went on holiday. He had a permanent indwelling urinary catheter. On the 3rd May 2013 he complained of abdominal pain and penile pain. It was noted his catheter was not draining as much as before. The care home called for the out of hours GP. The out of hours GP referred the case to the district nurse. The district nurse referred the case back to the out of hours. Due to a communication breakdown no one attended. The following day no further calls were made to either the district nurse or a doctor by the care home. ON the 5th May at 1pm Mr O'Connell's daughter visited him and found him extremely unwell. She called for an ambulance and he was taken to the Princess of Wales Hospital in Bridgend. He was diagnosed with sepsis from a urinary tract infection. He died later that evening.</p>
5	<p><u>CORONER'S CONCERNS</u></p> <p>During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <p>(1) There was a communication breakdown between the care home, district nurses and</p>

	<p>out of hours GP on the 3rd May 2013 resulting in Mr O'Connell not being seen by any clinical staff.</p> <p>(2) There was no direct monitoring of his oral input and urinary output at the care home which would have provided further evidence in support of a urinary tract infection.</p> <p>(3) Mr O'Connell did not have any clinical assessment of his condition for 2 days until his admission to hospital</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 18th October 2013. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons, Department of Health, Wales and the family.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>[DATE] 28/6/13 [SIGNED BY CORONER] </p>