REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive of Hywel Dda University Health Board Withybush General Hospital Fishguard Road Haverfordwest SA61 2PZ**
1	**CORONER** I am Jonathan Mark Layton senior coroner, for the coroner area of Carmarthenshire and Pembrokeshire.
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 18th July 2013 I commenced an investigation into the death of John Keith William Shelley then aged 68. The investigation concluded at the end of the inquest on 31 July 2014. The conclusion of the inquest was a narrative conclusion namely that the deceased had died on the 14th July 2103 from lobar pneumonia resulting from the ingestion of fairy liquid. The medical cause of death was: 1(a) lobar pneumonia
4	**CIRCUMSTANCES OF THE DEATH** (1) John Keith William Shelley who had suffered brain injury at birth was wholly dependent upon the care of others. (2) Following an assessment of his needs he was accommodated in a residential care home by the Health Board. (3) Given his propensity to drink any liquids, certain steps were taken to try to prevent Mr Shelley consuming harmful substances. (4) Despite this he was able to obtain and consume a quantity of fairy liquid from a bottle placed near to the kitchen window. (5) Having consumed the fairy liquid he quickly became ill. (6) There was a significant delay before advice was sought. The full extent of Mr Shelley's illness was not adequately communicated to the person from whom advice was sought. Thus an inadequate assessment of the situation was made. (7) Despite clear signs of Mr Shelley's deteriorating health no contact was made with emergency services for some time.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed this matter 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.

	The **MATTERS OF CONCERN** is as follows: That staff employed by the Health Board in caring roles should undertake basic first aid training and receive regular up-dates. There was information before the inquest that some staff at the residential unit had received no basic life support training and in relation to other staff members it was out-of-date.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 the 25 September 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 Person: [redacted] 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	**31 July 2014** **Signed: J M Layton**