REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** BCUHB, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd LL57 2PW
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 6th of January 2014 I commenced an investigation into the death of Nancy Hughes (DOB 26.06.30, DOD 03.01.14). The investigation concluded at the end of the inquest on the 11th of June 2015 and I recorded a conclusion of an accidental death. The cause of her death being due to 1(a) Bronchopneumonia and Congestive Cardiac Failure (b) Fractured Neck of Femur (Operated) and Arterial Atheroma (c) Fall 2. Alzheimer's Disease
4	**CIRCUMSTANCES OF THE DEATH** The Circumstances of the death are that the Deceased was a lady with Alzheimer's Disease and had been a patient on the Tawel Fan Ward at Ysbyty Glan Clwyd in June 2013 and had been placed on Risperidone before her discharge to a local care home at the beginning of July 2013. There was no review of this medication undertaken contrary to accepted medical practice and she fell at the care home on the 16th of December 2013 fracturing her hip. She underwent an operation to repair the fracture the following day but then had a further unwitnessed fall in hospital on the 28th of December whilst sitting out. She declined thereafter and passed away on the 3rd of January 2014.
5	**CORONER'S CONCERNS** 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. The **MATTERS OF CONCERN** are as follows :- 1. That there was no review of her medication in accordance with accepted medical practice and no system in place to ensure that this was undertaken. 2. That the evidence given by [redacted] Consultant Orthopaedic Surgeon suggested that there was no cohesion between mental health treatment and

	medical treatment such that whilst receiving medical treatment he would not have access to mental health information relating to a patient and as a result there may be no consideration given to the care given to vulnerable patients requiring additional support.
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 7th August 2015 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] (Son of the Deceased) 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] 12th June 2015 [SIGNED BY CORONER]** [redacted]