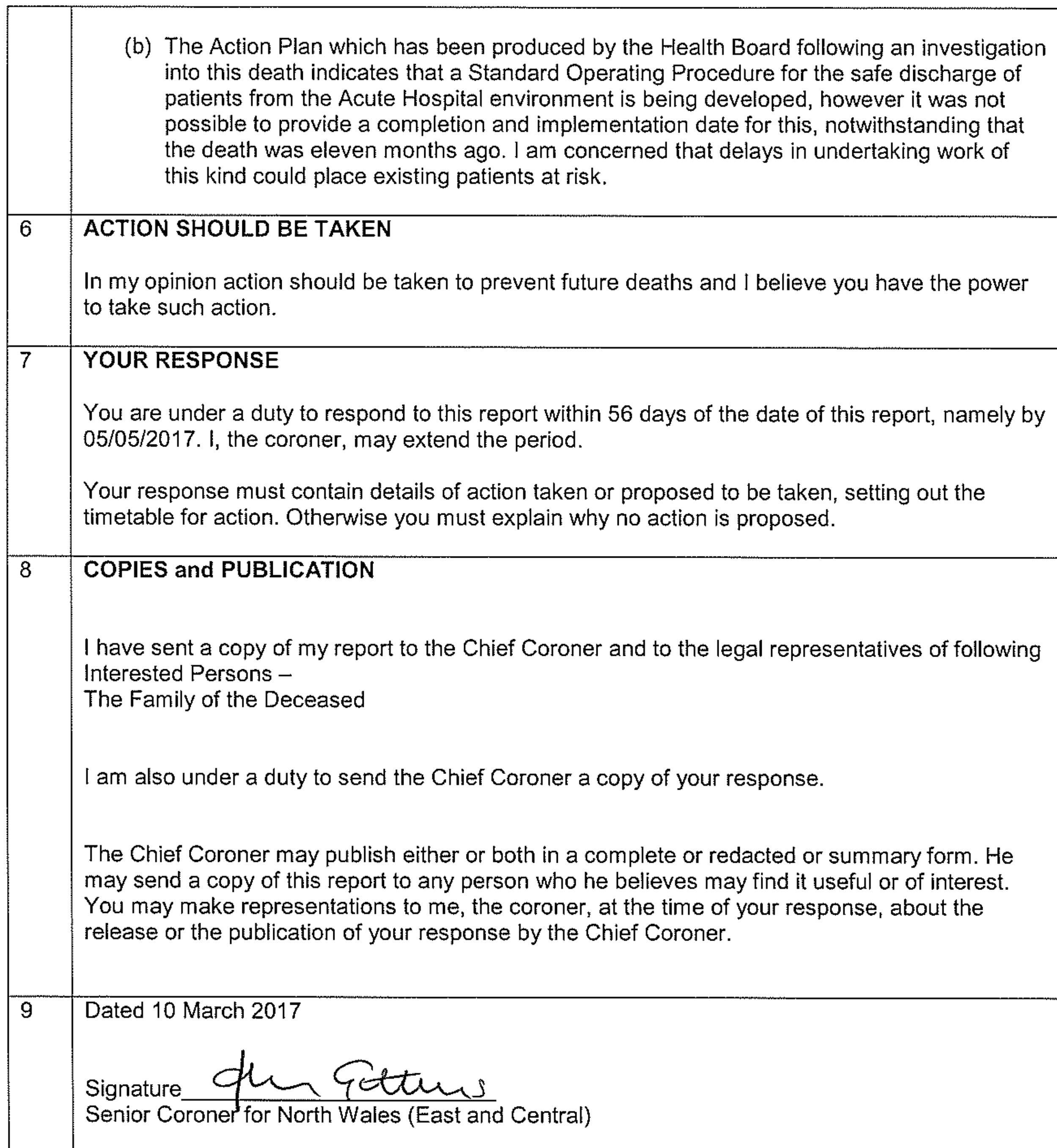
John Adrian Gittins
Senior Coroner for North Wales (East and Central)

	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 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 12/04/2016 I commenced an investigation into the death of Carol Ann Harvey, (DOB 6.4.42 DOD 9.4.16) The investigation concluded at the end of the inquest on the 7th of March 2017 The conclusion of the inquest was by way of a Narrative Conclusion as set out in paragraph 4 below
4	**CIRCUMSTANCES OF THE DEATH** Carol Ann Harvey was a seventy four year old lady who had been receiving medical treatment at the Wrexham Maelor Hospital. By the 6th of April 2016 plans were being made for her discharge home with care and support being provided to her by her family, carers and district nurses. On the 6th of April 2016 here INR was higher than was clinically ideal and this was being addressed by a reduction in her dosage. At around 4.15pm on the 7th of April 2016, following a delay arising from some confusion relating to a Tissue Viability Review, confirmation was received that Carol was to be discharged and a telephone call was made to the generic health care team to advise them of this so that the care plan could commence. A message was left on an answerphone to this effect but no confirmation was obtained that these instructions had been received. The answerphone was not checked until the following morning, notwithstanding that staff had returned to the office briefly around 7.00pm that evening. No carers attended Carol Harvey during the evening of the 7th of April and it is probable that in the course of that evening and overnight she was in considerable pain as a result of a calf haematoma and consequently took an accidental overdose of painkillers. At around 7.40am on the 8th of April she was found, drowsy and vomiting and she had suffered a large loss of blood which necessitated her readmission to hospital. Despite appropriate treatment for her condition she continued to decline and passed away at the Maelor Hospital in the early hours of the 9th of April 2016 due to a combination of the effects of the paracetamol overdose and a pre-existing cardiac condition.
5	**<u>CORONER'S CONCERNS</u>** 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. – (a) That although a referral had been made to the District Nurse Team, there is no procedure in place to ensure that such a referral has been both received and actioned.



	(b) The Action Plan which has been produced by the Health Board following an investigation into this death indicates that a Standard Operating Procedure for the safe discharge of patients from the Acute Hospital environment is being developed, however it was not possible to provide a completion and implementation date for this, notwithstanding that the death was eleven months ago. I am concerned that delays in undertaking work of this kind could place existing patients at risk.
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 05/05/2017. 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 legal representatives of following Interested Persons – The Family 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	Dated 10 March 2017 Signature__________ Senior Coroner for North Wales (East and Central)

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