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 24th of January 2014 I commenced an investigation into the death of Alan Walker (DOB 11.08.32, DOD 23.01.14). The investigation concluded at the end of the inquest on the 11th of December 2015 and I recorded a conclusion of Accidental Death
4	**CIRCUMSTANCES OF THE DEATH** (a) The Circumstances of the death are that on the 22nd of January 2014 a nasogastric feeding set was connected to the IV line of the deceased, which resulted in the intravenous infusion of liquid feed as a consequence of which he died the following day due to 1(a) Toxic Shock. (b) During the afternoon of the 22nd the NG tube had become detached from the feeding set on two occasions in quick succession and had thereafter been taped together, however these events were not recorded in the nursing notes and therefore other staff were not made aware that there may be a connectivity issue with this equipment during handover. Furthermore, staff handovers may not in any event be conducted by way of reference to the nursing notes.
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 :- That by not recording within the notes the type of issue referred to in paragraph 4 (b) above and then by not conducting handovers by reference to the nursing notes there is a risk that potentially significant information is not relayed to staff who come on duty at a later time.

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 8th February 2016 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] (Grand-daughter 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] 14th December 2015 [SIGNED BY CORONER]**