Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. Chief Executive, Blaenau Gwent County Borough Council
1	**CORONER** I am **Caroline Saunders,** Senior Coroner for the Area of Gwent
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 **13/10/20** an investigation was opened into the death of **Lynne Pamela LAWRENCE** The investigation concluded at the end of the inquest on: **23/4/21** The conclusion of the inquest was recorded as: **Death By Accident** The medical cause of death was: **1a) Subdural haemorrhage** **2 Atrial fibrillation**
4	**CIRCUMSTANCES OF THE DEATH** On 21st September 2020, Mrs Lynne Lawrence tripped on the pavement on her way home from Brynmawr. She was taken to hospital where the head injury she sustained was not initially diagnosed on scan but became evident after Lynne collapsed 2 days later. She had suffered an intracerebral haemorrhage made worse by the effects of warfarin which she took for atrial fibrillation. The bleed was catastrophic and Lynne Lawrence died at 15:54 on 23/9/20 in the Intensive Care Unit of the Royal Gwent Hospital in Newport.

5	**CORONER'S CONCERNS** During the course of the inquest, 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. <u>Condition of Pavement on</u> At the time of her fall, Mrs Lawrence was walking along a narrow pedestrian pavement near [redacted], Alma Street, Brynmawr, Newport, NP23. The video footage available to me at the inquest demonstrated that the pavement was uneven. Whilst I could not conclude that it was the unevenness of the pavement that caused Mrs Lawrence to fall, nonetheless I consider that this is a factor which could people's lives at risk in the future, especially the elderly with reduced mobility.
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. <u>I should be grateful if the following information be provided to me:</u> 1. Confirm whether any steps have or will be taken to address the quality of the pavement .
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely I, the Coroner, may extend this 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 necessary
8	**COPIES AND PUBLICATION** I have sent a copy of my report to the Chief Coroner and the following Interested Person (s) The family of Lynne Pamela Lawrence 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 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 17/5/21** Signed  Caroline Saunders **Her Majesty's Senior Coroner for the Area of Gwent.**