REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **CHIEF EXECUTIVE SWANSEA BAY UNIVERSITY HEALTH BOARD** **1 TALBOT GATEWAY** **BAGLAN ENERGY PARK** **BAGLAN** **PORT TALBOT** **SA12 7BR**
1	**CORONER** I am **Aled Gruffydd**, Assistant Coroner, for the coroner area of SWANSEA NEATH & PORT TALBOT
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 3rd July 2012 I commenced an investigation into the death of Catherine Jane Best. The investigation concluded at the end of the inquest on the 9th July 2021. The medical cause of death is 1a anoxic brain injury 1b) cardiac arrest 1c) malnourishment and sepsis The conclusion of the inquest as to how Ms Best came to her death was a narrative conclusion and is as follows:- The deceased was pronounced dead on the 23rd of June 2012 at Morriston Hospital, Swansea. The deceased died from an anoxic brain injury caused by a cardiac arrest, which itself was caused by a combination of sepsis and malnourishment. There was a failure to invoke NG feeding sooner when it became apparent that the oral offering wasn't being taken by the deceased. It cannot be determined whether this would have prevented the cardiac arrest suffered by the deceased on the 15th of June 2012.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was Catherine Jane Best and she was pronounced dead on the 23rd of June 2012 at Morriston Hospital, Swansea. The cause of death was an anoxic brain injury caused by a cardiac arrest, which itself was a combination of malnourishment and sepsis. Catherine was admitted to Morriston Hospital on the 5th of May 2012 in a malnourished

	state after suffering abdominal pain at home. Tests carried out on the 6th of May revealed she had a duodenal ulcer and had developed sepsis. On the same date she underwent surgery for repair. The post surgical period was eventful with Catherine in and out of Intensive Care suffering from infection. Up until the 17th of May Kate was fed using a combination of nasogastric feeding and oral intake. After that date the NG feeding was removed despite poor oral intake. After being transferred onto Ward V on the 2nd of June she suffered a cardiac arrest on the 15th of June and was found unresponsive in bed. A crash team were assembled and CPR was commenced. They managed to regain circulation, however Catherine had suffered a brain injury as a result of being without oxygen. From then on the prognosis was poor and Catherine passed away on the above date after life support was withdrawn.
5	**CORONER'S CONCERNS** During the course of the inquest it was apparent that the deceased was a complex and challenging patient and her appetite was poor. Although there were attempts to get her to eat, and alternatives offered, her calorific input remained poor. Up until the 17th of May Catherine was fed using a combination of nasogastric feeding and oral intake. After that date regular NG feeding was removed despite poor oral intake There were instances where NG feeding were re-introduced after that date but it was not consistent and there was no explanation for the removal of regular NG feeding on the 17th of May at a time when her oral intake was not sufficient to provide the required nutrition. Whilst encouraging Catherine to obtain her calories from oral intake was appropriate there was a regular pattern of her refusing her meals or eating less than the portions provided. There was a lack of documentary evidence verifying options and encouragement although assurances that this was being done was provided by way of oral evidence. I am concerned however that in cases involving difficult or challenging patients they may not be given adequate nourishment if the oral offering is refused or partly taken. This could result in situations where a patient's ability to recover is reduced due to insufficient nourishment. 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. There was an inadequate regime of supplemented feeding by way of nasogastric tube meaning that Kate was not receiving a consistent amount of calories per day to increase the chances of fighting infection. Kate was a challenging patient and it could not be guaranteed that Kate would always take her meals thus ensuring that her calorie intake was obtained orally.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you AND/OR your organisation 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 9 September 2021. 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 Persons [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	**15 July 2021** ..... **[SIGNED BY CORONER]**