Katie Sutherland Acting Senior Coroner
Senior Coroner for North West Wales

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: [redacted]AS Minster for Health and Social Services, [redacted]Corporate Director & Statutory Director of Social Services Gwynedd Council, [redacted]AS, Mabon ap Gwynfor AS, Rhun ap Iorwerth AS**
1	**CORONER** I am Katie Sutherland Acting Senior Coroner, Senior Coroner for North West Wales
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 20/07/2021 I commenced an investigation into the death of Eirlys Wynne Roberts, aged 93 . The investigation concluded at the end of the inquest on 26 January 2022. The conclusion of the inquest was: Death was due to natural causes contributed to by a fall which caused a fractured neck of femur and upon which was operated.
4	**CIRCUMSTANCES OF DEATH** Eirlys Wynne Roberts was 93 years of age at the time of her death on 17.7.21. There had been a general decline in her cognitive health and despite extensive support and care from her family there came a time when further additional care was required. She took a placement at a residential home where she suffered a fall. She was taken to hospital where she was found to have a fractured neck of femur and it was deemed appropriate to operate. Despite overcoming the surgery she sadly passed away a short time later.
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. There was evidence heard during the Inquest that when a residential home was required given the deceased's needs that the homes in Gwynedd were all full and that consideration would need to be given to placements outside of the area. Eventually a placement was identified. When further deterioration was noted whereby the deceased required a higher level of care by way of an EMI residential placement one was not immediately available. The deceased therefore remained at the residential home. When her needs further increased whereby an EMI nursing placement was required, again there was no availability. I am concerned by the lack of available placements for the elderly as and when their cognitive and physical needs change thereby putting them at risk. The evidence was that there is a shortage of placements and it is concerning that specific needs of the elderly cannot always be met either at all or in a timely manner.

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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 28 March 2022. 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 Family 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 31 January 2022 Signature Sutherland. Acting Senior Coroner for North West Wales

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