REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Mark Drakeford AM, Minister of Health, Welsh Assembly Government** **2. [redacted], Clinical Director, Community Mental Health Services for Older People, Llandough Hospital**
1	**CORONER** I am Christopher John Woolley, Assistant Coroner, for the Coroner area of Cardiff and the Vale of Glamorgan
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 9th September 2013 I commenced an investigation into the death of John Elvet Morgan aged 88. The investigation concluded at the end of the inquest on 26th November 2013. The medical cause of death was: 1A Pulmonary Embolism in a man with dementia of Alzheimer's type, and the conclusion of the inquest was that the deceased died from natural causes.
4	**CIRCUMSTANCES OF THE DEATH** John Elvet Morgan was admitted to St Barruc's ward, Barry hospital on 29th August 2013 for respite care. He suffered from Alzheimer's dementia. On admission a red DNR (Do not Resuscitate) star was allowed to remain against his name on the whiteboard (or PSAG "Patient status at a glance Board") on the ward. In fact there had been no agreement that he was "DNR" and the red star had been left over by mistake from a previous patient's entry on the whiteboard. On 30th August 2013 John Elvet Morgan collapsed on the ward. He was not resuscitated by staff on the ward as they relied on the red "DNR" star on the whiteboard. When the paramedics arrived no yellow DNR form was found in the notes as of course one did not exist. The PM report showed that John Elvet Morgan had suffered a pulmonary embolism.
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. – (1) The Whiteboard (or PSAG) is in use throughout Wales as a quick reference guide to the patients on the ward. It was introduced as part of the "Transforming Care at the bedside "TCAB" programme. Dr [redacted] Clinical Director for the University Hospital for Wales Board, confirmed that the information which is put on the whiteboard is a matter for local discretion. While the red "DNR" star system has been removed from the

	whiteboards in use in Cardiff and the Vale Local Health Board he could not say whether similar systems are not in use elsewhere in Wales. (2) The whiteboard system is a useful reference point for patient care but there is a danger that the information held on the whiteboard is relied upon instead of the patient's notes. (3) Human error may mean that erroneous information is held on the whiteboard to the detriment of patient care. (4) A similar DNR "red star" system may be in use on whiteboards in other Health Board areas in Wales with the possibility that a similar chain of events may occur elsewhere in Wales.
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 11th February 2014. 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 1. [redacted]. I have also sent it to [redacted] Medical Director, Cardiff and Vale University Health Board who may find it useful or of interest. 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	**17th December 2013** **C J Woolley, Assistant Coroner**