ANNEX A

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:** **1. The Chief Executive Cwm Taff Health Board** **2. Chief Coroner**
1	**CORONER** I am Andrew Roger Barkley, Senior Coroner, for the coroner area of Powys, Bridgend and Glamorgan Valleys
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 4th April 2014 I commenced an investigation into the death of Vivian Herbert HUNT aged 84. The investigation concluded at the end of the inquest on 6th August 2014. The conclusion of the inquest was that Mr Hunt had died from the effects of a subdural haemorrhage following an un-witnessed fall he had in his hospital room on 3rd April 2014.
4	**CIRCUMSTANCES OF THE DEATH** Mr HUNT was a patient on the Mental Health ward of the Royal Glamorgan Hospital when he was found to have fallen in his room in the early hours of the morning of 3rd April 2014 sustaining an injury to the side of his face. He had fallen in similar circumstances the day before. Throughout the day he deteriorated until he became unresponsive and a subsequent CT scan showed a bleed on his brain from which he later died the following day.
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. – (1) Despite the fall he suffered on 2nd April and despite suffering a clear injury to his face in the fall on 3rd April 2014, no neurological observations were made of him between 5am on 3rd April and between 12:30 and 13:15pm that day.
6	**ACTION SHOULD BE TAKEN**

	In my opinion action should be taken to prevent future deaths and I believe you and 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 3rd October 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 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	**6th August 2014** **SIGNED:**