REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive of Withybush General Hospital Fishguard Road Haverfordwest Pembrokeshire SA61 2PZ**
1	**CORONER** I am Jonathan Mark Layton senior coroner, for the coroner area of Carmarthenshire and Pembrokeshire.
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 6th May 2014 I commenced an investigation into the death of Ian Page then aged 86. The investigation concluded at the end of the inquest on 12th September 2014. The conclusion of the inquest was one of accidental death. The medical cause of death was: 1(a) fracture of cervical spine 1(b) ischaemic heart disease, fracture of left hip
4	**CIRCUMSTANCES OF THE DEATH** (1) Mr Page was admitted to Withybush General Hospital on 26th April 2014 following a fall at home. (2) He underwent surgery at the Hospital. Following the operation Mr Page remained in hospital. Mr Page had dementia and would make repeated attempts to leave his bed despite his recent surgery. (3) On the 28th April at approximately 23.10 hours he got up from his bed and fell fracturing his cervical spine. (4) His condition deteriorated and he died on the 2nd May 2014.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed this matter 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. There was a training need identified regarding communication following patient handover. 2. No risk assessment was carried out on Mr Page identifying the risk of falls. 3. There was no low bed available to Mr Page. 4. A review of the provision of nursing staff was identified when patient circumstances require greater staffing levels.

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 the 7th November 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 Person: [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	**12 September 2014** **Signed:**