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. Chief Executive of Cwm Taf Health Board** **2. Chief Coroner** **3. Family –** [redacted]
1	**CORONER** I am Andrew 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 18th September 2014 I commenced an investigation into the death of Martin Dilwyn McCabe aged 66. The investigation concluded at the end of an inquest on the 19th November 2014. The conclusion of the inquest was Narrative Conclusion "Martin Dilwyn McCabe died as a result of the effects of a head injury which he sustained when he suffered an unwitnessed fall on ward 15 of the Royal Glamorgan Hospital on the 14th September 2014", medical cause of death was 1a. Extensive Bilateral Subdural Haemorrhage, 2. Myelofibrosis.
4	**CIRCUMSTANCES OF THE DEATH** Mr McCabe was admitted from an inpatient clinic on the 11th September 2014 onto ward 15 of the Royal Glamorgan Hospital. This was because he was experiencing bleeding from his gastro intestinal tract. This was successfully treated. He was being assisted by a nurse on the evening of the 14th September out of bed to use a "bed bottle" and was left unattended after which he fell to the ground and suffered a serious injury to his head. A CT scan revealed extensive bilateral subdural haemorrhage as a result of the fall. He passed away the following day on the 15th September 2014.
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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) Upon his admission to ward 15 on the 11th September no risk assessment in relation to his risk of falling was carried out. Staff relied on a risk assessment which had previously been carried out 3 months before this admission and did not update it with relevant information such as a history of two falls whilst at home and also the use of

	night time sedation whilst on the ward. Both of these factors were accepted by the health board to be material factors in a risk assessment and which may well have had a bearing in the way in which staff dealt with him on the ward.
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 15th January 2015. 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, Cwm Taf Health Board and the family 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	**20th November 2014** **SIGNED:** **Mr Andrew Barkley** **HM Senior Coroner**