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 **Re: Mr. Thomas Jenkins, who died on 08.08.14 at the Royal Glamorgan Hospital.** **THIS REPORT IS BEING SENT TO:** **1. Chief Executive Cwm Taf University Health Board** **2. HHJ Mr. Peter Thornton Chief Coroner,** **3. [redacted] Clinical Governance Lead Medicine & Accident and Emergency, Cwm Taf UHB;** **4. [redacted], Clinical Governance Lead Medicine & Accident and Emergency, Cwm Taf UHB;** **5. [redacted] NWSSP Legal & Risk Service; and** **6. [redacted] Son.**
1	**CORONER** I am Sarah-Jane Richards, Assistant 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 15th August, 2014 an investigation was commenced into the death of Mr. Thomas Jenkins. The investigation concluded at the end of the inquest on the 12th December 2014. The medical cause of death was 1a. Sepsis; 1b. Infected chronic pressure sore on right heel; and 1c. Cerebrovascular accident. The conclusion of the inquest was a narrative determination. **Narrative Conclusion:** *Mr. Thomas Jenkins, 85 years old, died on 8th August 2014 on Ward 12 of the Royal Glamorgan Hospital, Wales after developing a pressure ulcer whilst in the care of the Ysbyty Cwm Rhondda Hospital following a cerebral vascular accident. Mr. Jenkins was further diagnosed as suffering from cancer and his prognosis was poor. Treatment of the pressure sore failed, the ulcer worsened, became MRSA infected and was the likely source of sepsis which led to Mr. Jenkins' death.*
4	**CIRCUMSTANCES OF THE DEATH** Mr. Thomas Jenkins suffered a cerebral vascular accident and was admitted to the Royal Glamorgan Hospital on 27.12.13. He was transferred for rehabilitation to Ward C3, Ysbyty Cwm Rhondda on 04.02.14. He developed a pressure sore on his right heel which was first noted on11.04.14. At about this time he was diagnosed as MRSA positive at his PEG site, eyes and later his pressure sore wound. His pressure sore increased in severity from grade to 2 to a grade 3/4. He developed a further pressure sore on his right ankle and a left leg lesion. Maggot therapy was applied to his right heel

	wound and in this deteriorating condition he was transferred to a nursing home only to be re-admitted to the Royal Glamorgan Hospital within the week. He died 5 days later of sepsis.
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) Tissue Viability Nurse (TVN) input was requested at different times during the 7 month period whilst Mr. Jenkins was being nursed in YCR yet response was slow (as long as a week after a ward visit was requested). In fact the TVN did not assess the ulcer until 06.06.14 almost 2 months after its development and by which time the odour from the wound was described as 'very offensive'. A bandage used was reported as the likely cause of a new ulcer forming - Datix incident report 14.07.14. (2) The key concern is that of inadequate TVN and wound care input. The inadequate care in this instance was attributed to specialist nurses not being based in the hospital and of insufficient TVNs to serve the several hospitals in the region. The service being overstretched.
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. The consideration would be for increased availability of Tissue Viability Nurse care; implementation of NICE Guidelines and the All Wales Guidance on Essential Elements of Pressure Ulcer Prevention and Management; and training with spot checks to ensure accurate record keeping.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 18th February 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 Executive, Cwm Taf University Health Board; [redacted] Clinical Governance Lead Medicine & Accident and Emergency, Cwm Taf UHB; [redacted] Clinical Governance Lead Medicine & Accident and Emergency, Cwm Taf UHB; [redacted] NWSSP Legal & Risk Service; and Mr. [redacted] son. 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	**19th December 2014** **SIGNED:** S. J. Richards **Dr. Sarah-Jane Richards** **HM Assistant Coroner**