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 Coroner** 2. **Minister for Health, National Assembly for Wales** 3. **Chief Executive, Abertawe Bro Morgannwg University Health Board** 4. **Solicitor representing the family of Mr. Brain Francis**
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 17th September, 2014 I commenced an investigation into the death of Mr. Brian Francis. The investigation concluded at the end of the inquest on the 20th February, 2015. The conclusion of the inquest was natural causes.
4	**CIRCUMSTANCES OF THE DEATH** On the 5th September, 2014 Mr. Francis was admitted to Princess of Wales Hospital via A&E. He had been unwell for 3/4 days prior to admission and treated by his GP for an infection. On admission the presumptive diagnosis was that of chest sepsis and antibiotics were continued. The clerking process upon hospital admission failed on this occasion and Mr. Francis was not seen by the 'on duty' Consultant as he should have been. Had Mr. Francis been seen by the Consultant on admission his diagnosis may have been more accurately determined and therapeutic anti-coagulation therapy commenced. Instead, Mr. Francis died of a pulmonary embolism 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) The process of a Consultant's attendance on patient being noted by a 'tick in the box' on a paper record failed. The box had been ticked when in fact the patient had not been reviewed by the Consultant. (2) Had the Community medical records been available at the time of hospital admission the patient would most probably have been assessed differently and in all probability, anti-coagulation therapy commenced immediately or shortly thereafter.

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 in the area of: ➢ Ensuring patients once 'clerked' within emergency medicine have prompt Consultant review. ➢ Notification that the review has occurred to be indicated to Ward staff. ➢ For Community Health Care records to be electronically available to Emergency Medicine Departments
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 1st May, 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; Mr. Mark Drakeford, Minister of Health, National Assembly for Wales; Mr. Paul Roberts, Chief Executive, Abertawe Bro Morgannwg University Health Board; [redacted] Chest Consultant who undertook the Stage 2 Mortality Review; and to the Legal Representative of the Francis family. 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	**4th March 2015** **SIGNED:** [redacted] **Dr. Sarah-Jane Richards** **HM Assistant Coroner**