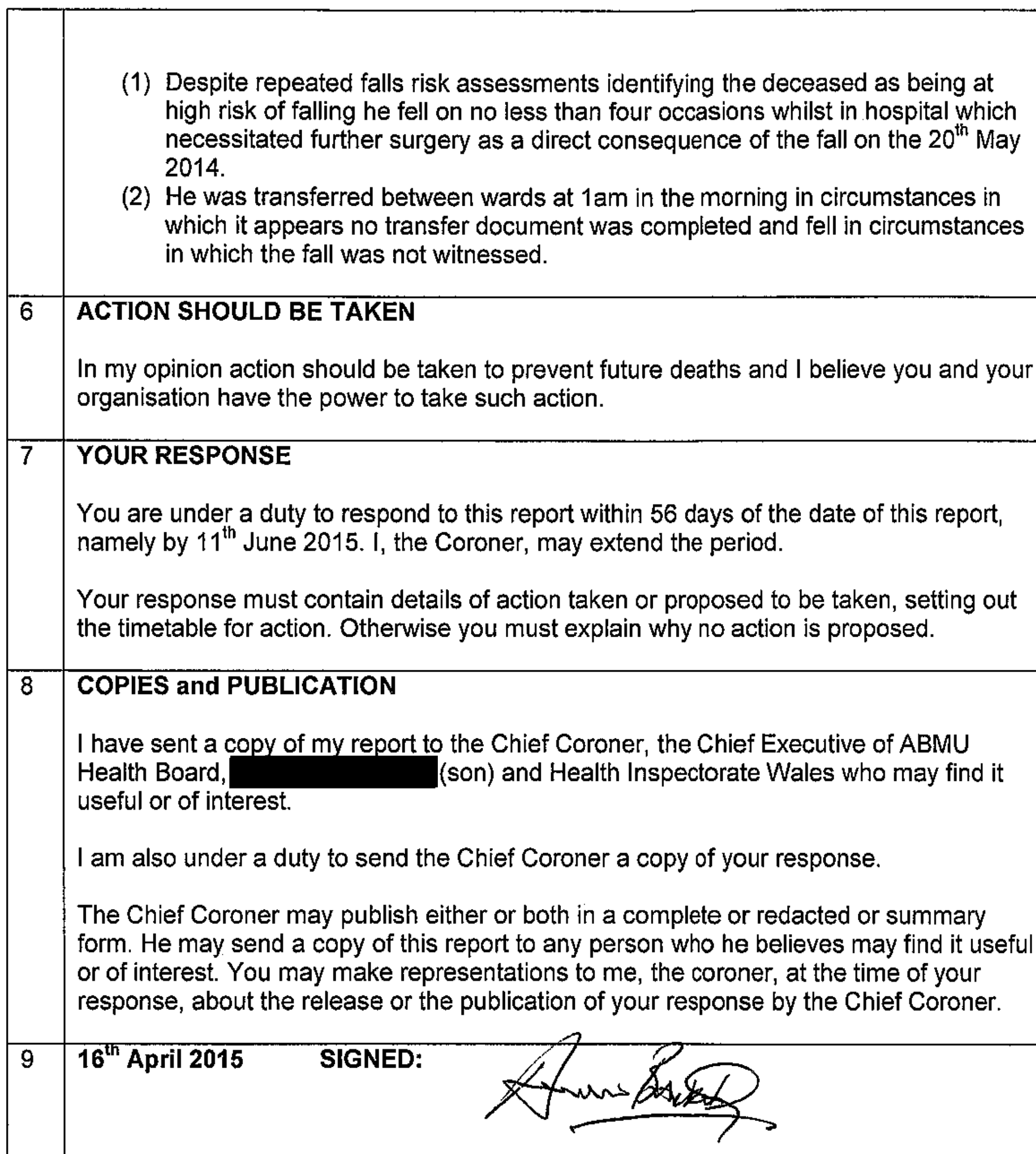
ANNEX A

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 ABMU Health Board** **2. [redacted] - Son** **3. Chief Coroner** **4. Health Inspectorate Wales**
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 23rd July 2014 I commenced an investigation into the death of Robert Henry Payne, investigation concluded at the end of an inquest on today's date which is the 14th April 2015. The conclusion of the inquest was a narrative conclusion *"Robert Henry PAYNE died as a result of infection which he suffered having undergone surgery to repair a fractured neck of femur which he sustained in a fall at his home address on 9th May 2014 and which required further surgery as a result of a further fall and dislocation which he sustained whilst in hospital".*
4	**CIRCUMSTANCES OF THE DEATH** The deceased was admitted to the Princess of Wales Hospital in Bridgend on the 9th May 2014 having fallen at his home address and fractured his left neck of femur. The femur was repaired on the 9th May 2014 and he was managed on the ward. He fell on the ward, not sustaining any injury on the 12th May and again on the 17th May. He was transferred between two wards in the small hours of 20th May and within hours fell again dislocating the hip which had been repaired. This necessitated further surgery and it became apparent that the surgical wound had become infected. He had one further fall on the 2nd June whilst in the care of physiotherapists. His condition deteriorated and he passed away on the 13th July.
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 repeated falls risk assessments identifying the deceased as being at high risk of falling he fell on no less than four occasions whilst in hospital which necessitated further surgery as a direct consequence of the fall on the 20th May 2014. (2) He was transferred between wards at 1am in the morning in circumstances in which it appears no transfer document was completed and fell in circumstances in which the fall was not witnessed.
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 11th June 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, the Chief Executive of ABMU Health Board, (son) and Health Inspectorate Wales 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	**16th April 2015 SIGNED:**