ANNEX A

## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>1. **Mr Adam Cairns, Chief Executive – Cardiff & Vale NHS Trust**<br>2. [redacted] **Son**<br>3. **Chief Coroner** |
| 1 | **CORONER**<br><br>I am Andrew Barkley, Senior Coroner, for the coroner area of Cardiff & Vale of Glamorgan |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On the 14th January 2015 I commenced an investigation into the death of Elsie May Hayward aged 91. The investigation was concluded at the end of an inquest on 18th March 2015. The conclusion of the inquest was a narrative conclusion;<br><br>*"Elsie May Hayward died from the effects of sepsis having sustained a bleed on the brain which was caused when she is likely to have fallen from her hospital bed sustaining a head injury having fallen on three occasions in the preceding eight hours whilst at the University Hospital of Wales."* |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>The deceased was admitted to the University Hospital of Wales on the 18th December 2014 following a fall at home. During her stay in hospital she was being treated for sepsis. On the 7th January 2015 she sustained four separate falls; the last of which was believed to have been from her bed causing a head injury which on CT scanning revealed a subdural haematoma. Her condition deteriorated and she passed away three days later on the 10th January 2015. |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>1. On the 7th January 2015 medical staff were having to care for 50% more patients over what is generally considered to be safe staffed patient ratio. The evidence showed that the team was significantly overstretched and as a result |

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| | were not able to oversee the care to this lady. Because of the pressures on the team it is likely that there were deficiencies in the care afforded to her which may have contributed to her repeated falls.<br>2. Despite clear guidance and directive the neuro observations on the deceased following her head injury where not undertaken in accordance with the Health Boards procedure and the N.I.C.E. national guidance.<br>3. There were extensive omissions in the note taking and a clear inconsistency between the "nursing notes" and "clinical notes" resulting in confusion and a breakdown of communication between the nursing staff and the medical team. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 12th May 2015. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner who may find it useful or of interest.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 March 2015** **SIGNED:**  |