REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Mr Adam Cairns, Chief Executive, University Hospital of Wales, Cardiff** **2. [redacted] Consultant Geriatrician, University of Wales, Cardiff**
1	**CORONER** I am Christopher John Woolley, Assistant Coroner, for the Coroner area of Cardiff and the Vale of Glamorgan
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 4th March 2015 I commenced an investigation into the death of John Christopher Lloyd. The investigation concluded at the end of the inquest on 16th July 2015. The medical cause of death was: 1.A Hypoxic Brain Injury 1B Overdose of Opiates. I returned a conclusion of accidental death.
4	**CIRCUMSTANCES OF THE DEATH** Mr Lloyd suffered a serious injury to his left foot in 2002, as a result of which he was in chronic pain for the rest of his life. He was prescribed painkillers and anti-depressants, including morphine. I received evidence from several witnesses that he on occasion administered to himself an overdose of the morphine in order to control the pain. On 29th January 2015 he was admitted to UHW after having taken such an overdose. He was seen by [redacted] who was satisfied that it had been a therapeutic accident and not a suicide attempt. There is no criticism of the care he received between his admission on the 29th January 2015 and his discharge on the 30th January 2015. On discharge however no notification of the admission, whether by electronic means or paper, was sent to Mr Lloyd's GP. [redacted] candidly accepted that such a notification should have been sent to the GP as continuity of treatment is desirable in such cases. The GP was not therefore aware of this hospital admission until after Mr Lloyd's death (even though he held a consultation with him on 16th February 2015). Mr Lloyd's death occurred on the 27th February 2015 at UHW following a second overdose which I accepted was again an accident rather than deliberate. There is no criticism of the care of Mr Lloyd on the part of UHW from the time of his second admission on 18th February 2015 until his death on the 27th February.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed a matter 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 **MATTER OF CONCERN** is as follows. –

For Mr Adam Cairns, Chief Executive, UHW

(1) The notification that should have been sent to the GP after the first admission to UHW on 29th January 2015 was not sent. I heard evidence from [redacted] that this was not an isolated incident but arose quite often particularly in times of stress.

(2) [redacted] told me that an electronic system of notification had been introduced in mid-2014. This electronic system should therefore have been in place for Mr Lloyd but was not apparently utilised.

Had this information been available to the GP then it may have caused more questions to be asked at his consultation on the 16th February 2015 and may have led to a different course of treatment and outcome. The Coroner is concerned that UHW should employ systems to ensure the notification of admission to GPs in future cases to aid with the continuity of treatment. The Coroner is particularly concerned that failures in notification of admission occur quite frequently.

For Dr Butler, UHW Cardiff

(1) [redacted] informed me that he is now being put in charge of the notification system and that he intends to conduct an audit to ensure compliance. He is therefore in a key position to ensure that the electronic system of notification is used as intended.

The Coroner is concerned that [redacted] should be given adequate support from the management of UHW to carry out his important role in overhauling the notification system to GPs.

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe that (1) Mr Adam Cairns, Chief Executive, UHW and (2) [redacted] Consultant UHW 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 September 10th 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 and to the following Interested Persons 1. [redacted]

I have also sent it to the following persons:
Dr Ruth Hussey OBE, Chief Medical Officer, Welsh Assembly Government

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 July 2015**
C J Woolley **Assistant Coroner, Cardiff and the Vale of Glamorgan**