ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

<table>
<tr><td></td><td>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1. Chief Executive of ABMU Health Board
2. Minister for Health, Welsh Assembly Government</td></tr>
<tr><td>1</td><td>CORONER

I am Andrew Roger BARKLEY, Senior Coroner for the coroner area of South Wales Central.</td></tr>
<tr><td>2</td><td>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.</td></tr>
<tr><td>3</td><td>INVESTIGATION and INQUEST

On 6th April 2016 I commenced an investigation into the death of David Bassett COOPER aged 81. The investigation concluded at the end of the inquest, with a jury, on 15th December 2016. The conclusion of the inquest jury was that of a narrative conclusion and the medical cause of death was recorded as 1a. Acute on chronic subdural haematoma (traumatic) 1b Recurrent Falls 2. Hospital Acquired Pneumonia.

The narrative conclusion was "following a fall as an inpatient, Mr Cooper died of a traumatic brain injury, to which failure(s) in medical / nursing care contributed"</td></tr>
<tr><td>4</td><td>CIRCUMSTANCES OF THE DEATH

Mr COOPER suffered a traumatic head injury as a result of a road traffic collision in 1992, from which he recovered, and suffered a stroke in January 2009. He fell in the community and sustained a serious head injury on 12th October 2015 and was admitted to the Princes of Wales Hospital in Bridgend. Whilst in hospital, he was transferred between several wards and up to the time of his death, he suffered 9 separate falls. The final fall on 5th March 2016 caused a subdural haematoma from which he died.</td></tr>
<tr><td>5</td><td><u>CORONER'S CONCERNS</u>

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. –

[BRIEF SUMMARY OF MATTERS OF CONCERN]

1. When transfers between wards took place, the evidence revealed that there was</td></tr>
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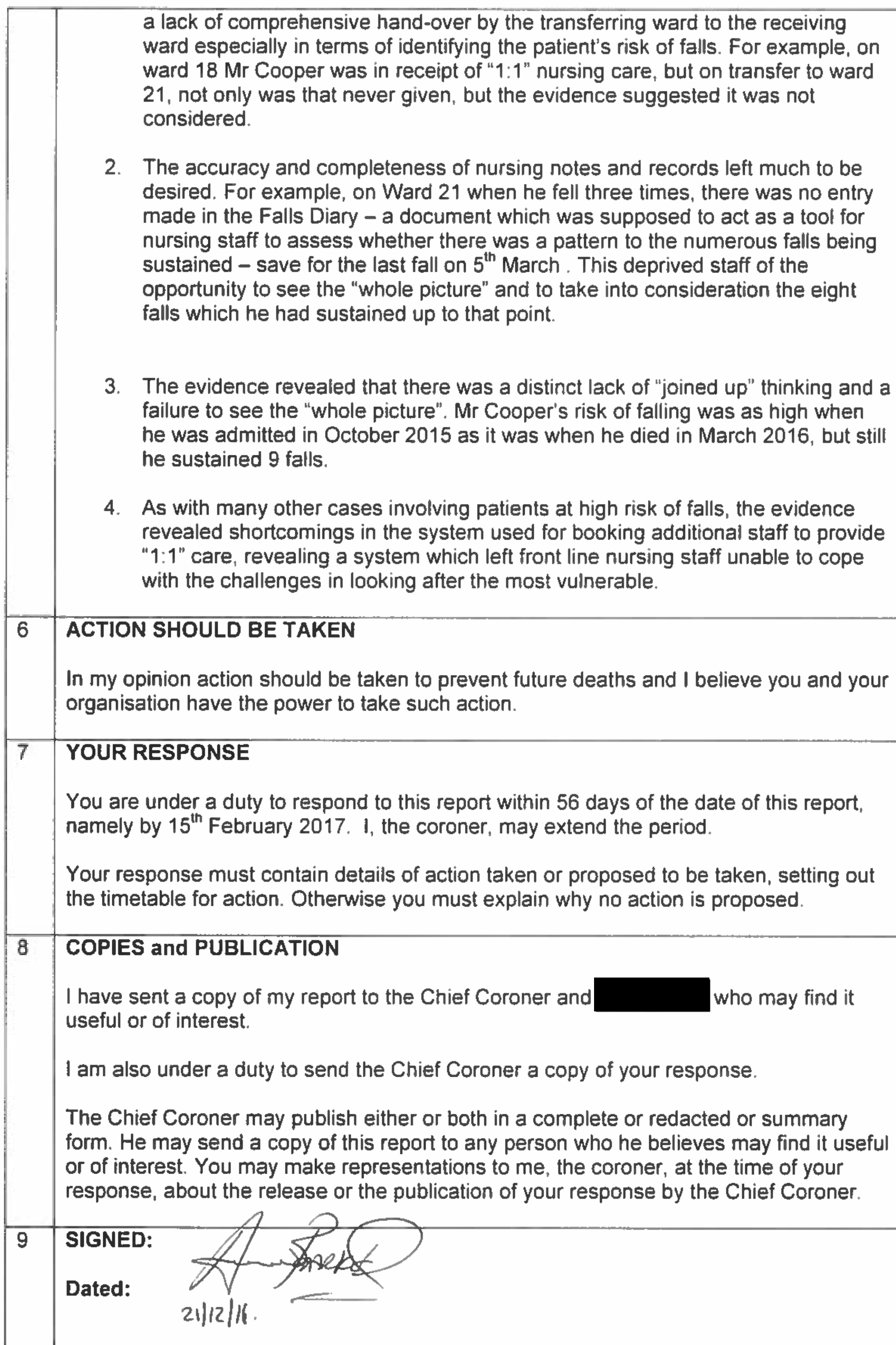

	a lack of comprehensive hand-over by the transferring ward to the receiving ward especially in terms of identifying the patient's risk of falls. For example, on ward 18 Mr Cooper was in receipt of "1:1" nursing care, but on transfer to ward 21, not only was that never given, but the evidence suggested it was not considered. 2. The accuracy and completeness of nursing notes and records left much to be desired. For example, on Ward 21 when he fell three times, there was no entry made in the Falls Diary – a document which was supposed to act as a tool for nursing staff to assess whether there was a pattern to the numerous falls being sustained – save for the last fall on 5th March . This deprived staff of the opportunity to see the "whole picture" and to take into consideration the eight falls which he had sustained up to that point. 3. The evidence revealed that there was a distinct lack of "joined up" thinking and a failure to see the "whole picture". Mr Cooper's risk of falling was as high when he was admitted in October 2015 as it was when he died in March 2016, but still he sustained 9 falls. 4. As with many other cases involving patients at high risk of falls, the evidence revealed shortcomings in the system used for booking additional staff to provide "1:1" care, revealing a system which left front line nursing staff unable to cope with the challenges in looking after the most vulnerable.
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 15th February 2017. 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 [redacted] 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	**SIGNED:** **Dated:** 21/12/16.