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 of Cwm Taf Health Board**
1	**CORONER** I am Andrew Barkley, Senior Coroner, for the coroner area of South Wales Central.
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 18th January I commenced an investigation into the death of Harold Mullins aged 92. The investigation concluded at the end of an inquest on the 18th April 2017. The conclusion of the inquest was that of "natural causes".
4	**CIRCUMSTANCES OF THE DEATH** The deceased was admitted to the Royal Glamorgan Hospital on the 3rd January having sustained a fall or collapse at his home address. No detail was known as to what may have caused that. On admission to hospital he was found to have a fracture to the left neck of femur. He had a raised INR level and an Acute Kidney Injury and therefore surgery was delayed until the 5th January. On the afternoon of that day he underwent surgical repair of the fracture to his hip. After surgery his standard observations (NEWS scores) were noted to be raised. In the early parts of the evening they continued to rise and assistance was sought by the nursing staff from one of the clinical team treating Mr Mullins. The Doctor indicated that "they were not concerned" as Mr Mullins had undergone surgery and did not examine him. The matter was then further escalated when his blood pressure fell further and no clinician was available to examine him. The initial contact with the treating clinician appears to have been at 2010 hours and the matter escalated again at 2145. On that occasion advice was given for fluids to be administered but again the treating clinician did not see Mr Mullins. By the time the clinician did see Mr Mullins he had suffered a cardiac arrest and despite efforts could not be resuscitated.
5	**CORONER'S CONCERNS** During the course of the inquest, and the investigation leading up to it, the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could 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) A review of the care that was received by Mr Mullins revealed that the surgical team were unaware of his history of deep vein thrombosis when undertaking the surgery and caring for him in general. (2) Despite a deteriorating position in relation to his observations (NEWS scores) he was not seen by a clinician in a timely fashion. There appears to be a difficulty in patients being seen in these circumstances appropriately by clinical staff which is a concern given that the purpose of the NEWS score system is to escalate care in cases of deterioration. It is a concern that the clinician contacted initially when the NEWS scores were deteriorating indicated that this was to be expected given that he had undergone surgery.
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 13th June 2016. 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 Welsh Assembly Government and the family 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	**20th April 2017** **SIGNED:** **Mr Andrew Barkley** **HM Senior Coroner**