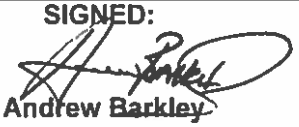
ANNEX A

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. [redacted] **Tynant Nursing Home, Cymmer, Port Talbot** 2. **ABMU 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 11th January 2017 I commenced an investigation into the death of Hedley Greenland. The investigation concluded at the end of an inquest on 20th September 2017 and the conclusion of the inquest was that of a narrative conclusion:- "*Hedley Greenland died from the effects of a urine infection in circumstances in which no adequate monitoring of his fluid input and catheter output took place for over 9 hours".* The medical cause of his death was recorded as 1a. E Coli septicaemia from urinary tract infection 2. Chronic kidney disease, frailty, old age, ischaemic heart disease.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was residing in the Tynant Nursing Home in Cymmer. He had a number of comobidities which included prostate cancer. As a result of the cancer he was permanently catheterised. Around the 14th December 2016 staff suspected he may be suffering with a urinary tract infection and his GP was consulted and a sample of urine sent for analysis. That indicated the presence of two "bugs" and the advice was to monitor his condition and if he were to show any signs of being systemically unwell further advice should be sought with a view to administering antibiotics. From the 14th December there was no sign that he was systemically unwell. The nurse on duty overnight on Friday 16th December was made aware of the position and the fact that he had not taken much fluid. She drained his catheter bag at 00.15am on Saturday 17th December and formed the view that he was dehydrated. She gave him additional fluids but noted that there was no further drainage from the catheter throughout the night until the end of her shift at 7.30 on the 17th December. Around 9.30 on the 17th December it was noted that he had become acutely unwell and upon being re-catheterised approximately 600ml of purulent urine was drained from the catheter and it was suspected that he maybe septic and an ambulance was called. He was conveyed to hospital to the Princess of Wales Hospital where it was noted that he was bravely ill and his condition deteriorated and he passed away on the 20th December 2016.

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 fluid balance chart should have been used by nursing staff to monitor fluid intake and urine output. There was no evidence that one had been thus rendering it impossible to measure urine output which might have indicated a blockage and/or infection. It was apparent during the course of the evidence that the nurse in charge of Mr Greenland's care did not consider actively monitoring his urine output, neither did she consider flushing the catheter. There was no written handover, as the evidence showed is normally the practice, to the incoming nursing team the following morning. There was no clear evidence that the lack of urine output had been noted by the night shift with a view to escalating his care. The evidence revealed that there was no urine output for at least 9 hours but probably substantially more than that. (2) The qualified nurse on duty overnight 16th/17th December was not trained in male catherisation. (3) There was no evidence in the medical/nursing notes that the "Catheter Care Bundle" was being used. (4) The evidence given by two nurses involved in Mr Greenland's care revealed a clear lack of understanding, knowledge and training as to how to manage a long term indwelling catheter.
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 21st November 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: 1) Chief Coroner 2) The family 3) Minister of Health Welsh Assembly Government 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	**26th September 2017**	**SIGNED:**  **Mr Andrew Barkley** **HM Senior Coroner**