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. Chief Executive 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 14th March 2017 I commenced an investigation into the death of Dennis George Redmore aged 88. The investigation concluded at the end of an inquest on the 3rd August 2017. The conclusion of the inquest was that of a narrative :- *"Dennis George Redmore died as a result of the effects of a head injury which he sustained when he fell in Hospital. The evidence did not reveal a clear cause for the fall but it is likely that his medical conditions, both acute and chronic, contributed."*
4	**CIRCUMSTANCES OF THE DEATH** The deceased was admitted to hospital in the early hours of the 6th March 2017 suffering with the effects of a blocked catheter and presumed urinary tract infection. He was suffering with lymphoma and was being treated palliatively at the time. He had had urinary issues in the past. On being transferred from the A&E Department to the Acute Medical Unit he sustained an unwitnessed fall in the toilet around 8pm was put back to bed and kept under observation. Observations commenced after the fall at 8:15pm on the 6th March through to 7:30 AM on the 7th March when an acute deterioration in his condition was noted. A subsequent CT scan revealed a subdural haematoma, which is not suitable for surgical intervention. His condition deteriorated and he passed away later the same evening.
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) There where clear failures to monitor the deceased neurologically with gaps of several hours between observations. He should have been monitored every 30 minutes but was in fact, according to the evidence monitored at 20:15, 21:00, 22:00, 23:00, 01:00, 04:00, 07:30 and 08:50. "NEWS" observations were carried out and one was carried out at 06:20 on the morning of the 7th March which revealed an elevation in blood pressure and pulse. That was not acted upon for approximately another hour. The evidence suggested that the observations may have undertaken but not recorded. The clear concern is that observations were not carried out in accordance with local and national guidance. There was no clear evidence in this case that the lack of observations had in fact caused or contributed to the death of Mr Redmore but this must give rise to a concern for the welfare of others. No appropriate management of the nurse responsible for the observations was in place to ensure the checks were carried out.
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 4th October 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, 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	**9th August 2017** **SIGNED:** **Mr Andrew Barkley** **HM Senior Coroner**