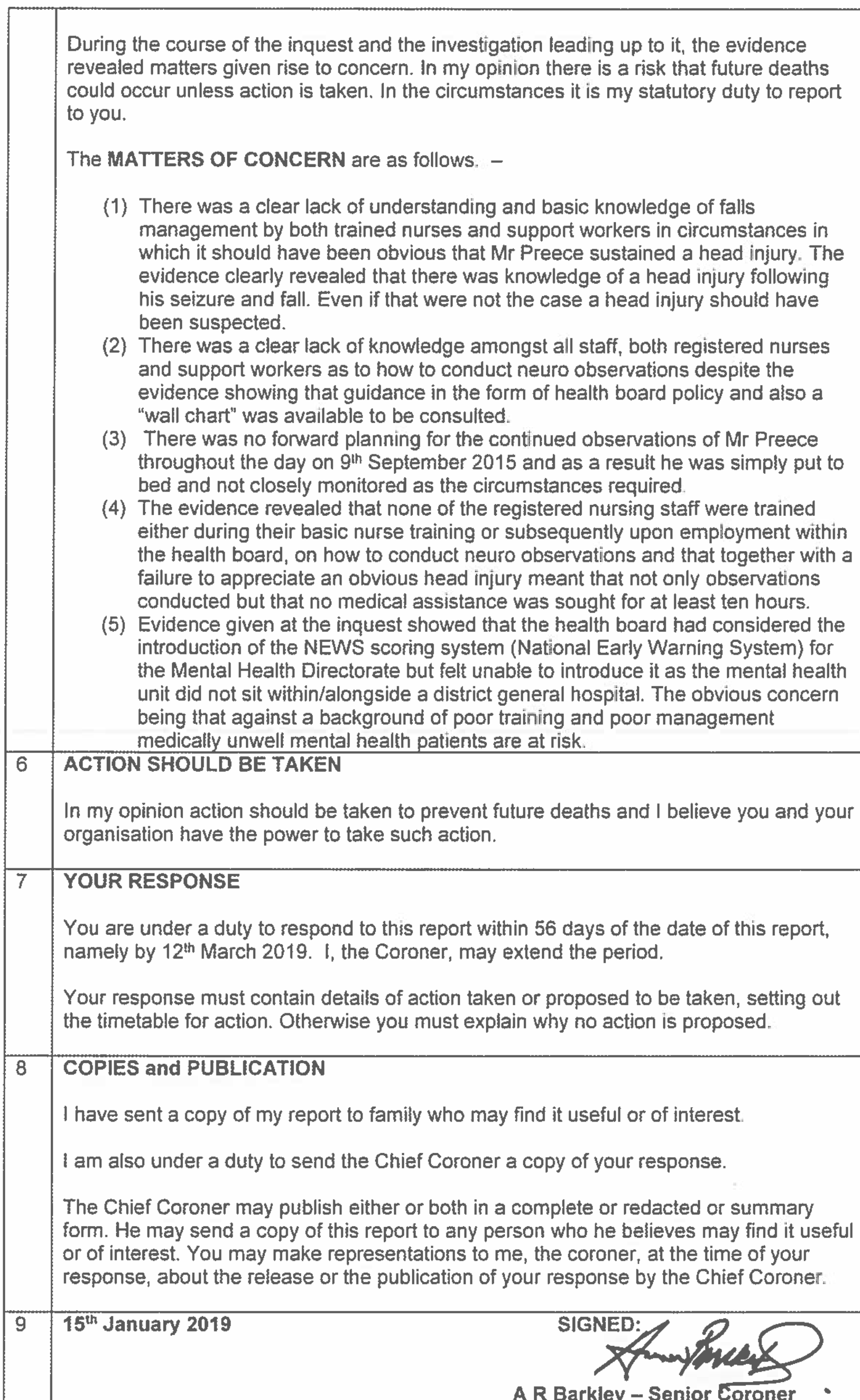
ANNEX A

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, Cardiff & Vale University Health Board** **2) Ms Andrea Sutcliffe CBE, The Chief Executive, Nursing & Midwifery Council**
1	**CORONER** I am Andrew Roger 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 17th September 2015 I commenced an investigation into the death of John Preece aged 62. The investigation concluded that the end of the inquest, sitting with a jury on the 13th December 2018. The conclusion of the inquest was that of a narrative conclusion, namely *"Mr Preece died of a subdural Haemorrhage as a result of a traumatic brain injury following a fall"*. The delay in hearing the inquest was in the main due to a criminal prosecution before the crown court.
4	**CIRCUMSTANCES OF THE DEATH** These were recorded as :- The deceased John Preece suffered with early onset dementia which was diagnosed in 2010. In November 2013 he spent time in Llandough Hospital and in September 2014 was admitted on a full time basis to the St Barrucs unit a small unit for male patients at Llandough Hospital. It was known that he was prone to seizures which were believed to be related to his progressive dementia. On the 9th September 2015 at about 9am in the morning he suffered a witnessed seizure which caused him to fall to the floor and sustain a serious injury to his head. He was put to bed and remained there until approximately 7 o clock in the evening when concern was raised for his welfare. There were incomplete and inappropriate physical and neuro observations undertaken of him during this period. Upon his admission to hospital a life threatening injury was suspected. This was subsequently shown at post mortem examination. He passed away within two hours of admission at the University Hospital of Wales in the early hours of the morning on the 10th September 2015.
5	**CORONER'S CONCERNS**



During the course of the inquest and the investigation leading up to it, the evidence revealed matters given 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. –

(1) There was a clear lack of understanding and basic knowledge of falls management by both trained nurses and support workers in circumstances in which it should have been obvious that Mr Preece sustained a head injury. The evidence clearly revealed that there was knowledge of a head injury following his seizure and fall. Even if that were not the case a head injury should have been suspected.

(2) There was a clear lack of knowledge amongst all staff, both registered nurses and support workers as to how to conduct neuro observations despite the evidence showing that guidance in the form of health board policy and also a "wall chart" was available to be consulted.

(3) There was no forward planning for the continued observations of Mr Preece throughout the day on 9th September 2015 and as a result he was simply put to bed and not closely monitored as the circumstances required.

(4) The evidence revealed that none of the registered nursing staff were trained either during their basic nurse training or subsequently upon employment within the health board, on how to conduct neuro observations and that together with a failure to appreciate an obvious head injury meant that not only observations conducted but that no medical assistance was sought for at least ten hours.

(5) Evidence given at the inquest showed that the health board had considered the introduction of the NEWS scoring system (National Early Warning System) for the Mental Health Directorate but felt unable to introduce it as the mental health unit did not sit within/alongside a district general hospital. The obvious concern being that against a background of poor training and poor management medically unwell mental health patients are at risk.

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 12th March 2019. 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 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 15th January 2019 **SIGNED:**

A R Barkley – Senior Coroner