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:** **CHIEF EXECUTIVE ABMU HEALTH BOARD** **1 TALBOT GATEWAY** **BAGLAN ENERGY PARK** **BAGLAN** **PORT TALBOT** **SA12 7BR**
1	**CORONER** I am **Aled Gruffydd**, Assistant Coroner, for the coroner area of SWANSEA NEATH & PORT TALBOT
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 29th March 2018 I commenced an investigation into the death of Pamela Moran. The investigation concluded at the end of the inquest on 11th November 2019. The medical cause of death is 1a) acute on chronic intracranial bleed 2 anticoagulation for metallic mechanical heart valve, osteoporotic fracture of neck of femur and elbow (not operated on) ischaemic heart disease, dementia The conclusion of the inquest as how Mrs Moran came to her death was accidental death.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was Pamela Moran and she was pronounced dead on the 17th of March 2017 at Morriston Hospital, Swansea. The cause of death was an acute on chronic intracranial bleed caused by a fall in the parking area of Tonna Hospital, where she suffered a fracture to her right hip, right elbow, and a head injury. Pamela was transferred to Morriston Hospital where the fractures to the hip and elbow were diagnosed. A request was made for a CT scan to assess the extent of the head injury however this was refused as a fractured hip and elbow do not fulfil the criteria for a CT head scan to be performed. It was not explained during that conversation however that Pamela was on warfarin, and had suffered a previous chronic subdural haematoma three months prior. This information would have brought Pamela within the criteria of a CT head scan. The CT head scan was eventually performed on the 16th of March 2017,

	some 40 hours after admission and after Pamela had begun to experience neurological signs. The CT scan showed an acute on chronic intracranial bleed, by which time the only treatment options being palliative care. It was found that there was a total of three missed opportunities (including the above) to ensure that the CT scan was done. It could not be stated whether an earlier CT scan in this case would have prevented death. The circumstances relating to Pamela's fall at Tonna Hospital has been the subject of a Serious Incident Review by the Health Board and steps have been put in place to avoid a reoccurrence. Accordingly this report is not concerned with the circumstances surrounding the fall but in respect of the matters that arose following it.
5	**CORONER'S CONCERNS** During the course of the inquest a report from Dr [redacted] instructed as an independent expert in this case, found 3 missed opportunities for the CT head scan to be performed. Dr [redacted] conclusion noted at paragraph 6.5.6 that: "Regional neurosurgical services keep a record of the cases referred to them and discuss all cases at a handover meeting so that if the advice given is to carry out certain investigations or initiate a line of management and then ring back the second doctor giving advice has access to the earlier information. The discrepancy between D[redacted] account and Dr[redacted] account of the conversation on the evening of 14 March 2017 about Mrs Moran unfortunately cannot be clarified by the use of structured documentation generated by either or both parties. Dr [redacted] states that he was not given Mrs Moran's name and has relied on his memory about anticoagulation and a previous CSH not being mentioned. The local system does not seem to facilitate an overnight consultant authorising a next day CT scan but relies on the junior doctors to hand over the task of requesting the scan again, possibly twice - firstly from the evening to the night shift doctors and then the night shift doctor to a third, different morning shift doctor. There may be other radiology services that have developed formal systems which the Health Board could adopt." 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. – 1. There were 3 missed opportunities for a CT scan to be undertaken in this case, which may have prevented the deceased's death, or at the very least improved her prospects of survival. 2. There appeared to be no documentation relating to the discrepancy between the accounts of Drs [redacted] n respect of their conversation on the 14th of March 2017. 3. There does not appear to be a facility for an overnight consultant to authorise a next day CT scan, and relies on a junior doctor to hand over the task at the end of their shift.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you AND/OR 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 7 January 2020. 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 to the following Interested Persons [redacted] 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	**12 November 2019** ..... **[SIGNED BY CORONER]**