**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**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**The Chief Executive of the Cwm Taf University Health Board** |
| 1 | **CORONER**<br><br>I am David Regan, Assistant Coroner, for the Coroner area of South Wales Central |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>A Coronial investigation was commenced on 20th July 2018 into the death of Thomas William Browne. The Investigation concluded at the end of the inquest which I conducted on 25th November 2019. The conclusion was that the death occurred as a result of natural causes and the medical cause of death was 1 (a) Chronic Obstructive Airway Disease; 1(b) Corpulmonale; 2 Hypertension; Previous Myocardial Infarction |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>These were recorded as :-<br><br>Thomas William Browne, known as "Bill", was found in a collapsed state in a toilet at ward 12, Prince Charles Hospital, Merthyr Tydfil at about 12.45 pm on 17th July 2018. He had been taken to the toilet by a nurse and left unaccompanied. His Oxygen supply cylinder was found exhausted when he was found.<br><br>The Inquest focused upon:- |

| | |
|---|---|
| | a. The fact that Mr Browne was a highly vulnerable patient reliant upon non-invasive ventilation by Oxygen<br>b. He was taken to the lavatory by a member of nursing staff, using an Oxygen Cylinder said to have been found by her by his bedside.<br>c. The Nurse left him unaccompanied in the lavatory, did not inform any other member of staff that she had done so, and left the ward.<br>d. Mr Browne was found in a collapsed state in the lavatory approximately 45 minutes later<br>e. His Oxygen supply was exhausted when he was found. |
| 5 | **CORONER'S CONCERNS**<br><br>During the course of the inquest the evidence revealed matters giving rise to concern. 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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>(1) Although on the evidence at the Inquest, a finding was made that Mr Browne died from natural causes, the evidence gives rise to the concern that patients may be left unaccompanied while being dependent upon a finite supply of Oxygen, where no systems are in place for ensuring that they are monitored and assisted before such supplies run out.<br><br>(2) The root cause analysis was accepted in evidence by the Trust to be deficient in that it did not identify and address this issue.<br><br>(3) Training in the administration of Oxygen remains incomplete.<br><br>(4) There are no formal procedures for recording the time that the finite supply of Oxygen to patients will expire. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 24th 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**<br><br>I have sent a copy of my report to family who may find it useful or of interest.<br><br>HeaIth Inspectorate Wales, Welsh Government, Medical Director of Cwm Taf University Health Board.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **25th November 2020** **SIGNED:**<br>**D Regan**<br>**Assistant Coroner**<br>**(Electronic signature)** |