Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. Chief Executive of Aneurin Bevan University Health Board
1	**CORONER** I am **Caroline Saunders,** Senior Coroner for the Area of Gwent
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 **28/1/2020** an investigation was opened into the death of **Valmai Ann WEST** The investigation concluded at the end of the inquest on: **1/7/2021** The conclusion of the inquest was recorded as: **Death By Accident** The medical cause of death was: **1a) Intracranial Haemorrhage** **1b) Fall**
4	**CIRCUMSTANCES OF THE DEATH** Valmai West suffered 2 falls in the community on 11th and 16th January 2020 respectively and attended the Emergency Department of the Royal Gwent Hospital. On neither occasion did she present with any signs of intracranial haemorrhage or cerebral irritation. Mrs West had also suffered a fracture of her pubic ramus on 16th January and was admitted to hospital for management of the fracture and rehabilitation. On 20th January Mrs West was found to be unresponsive and a CT scan demonstrated an extensive subdural haemorrhage. The effect of this bleed was devastating and Mrs West died on 22nd January 2020 at the Royal Gwent Hospital.

5	**CORONER'S CONCERNS** During the course of the inquest, 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. The **MATTERS OF CONCERN** are as follows: - 1. <u>Staffing Levels in the Emergency Department of Royal Gwent Hospital</u> During the course of the inquest, consideration was given to the the clinical decisions made in the Emergency Department of the Royal Gwent Hospital. I concluded that there was no evidence that Mrs West was displaying signs that would alert the staff to a possible intracranial bleed. However in evidence Dr [redacted] Consultant in Emergency Medicine, acknowledged that the staff had not followed hospital protocol or the NICE guidance in relation to the frequency with which observations should be performed. Dr [redacted] assessment of the situation was that this was probably caused by inadequate staff numbers to undertake the full range of duties required. She further stated that this is a frequent and ongoing problem in the Emergency Department. Whilst this did not influence the outcome for Mrs West I am concerned that this may put the lives of future patients at risk.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. <u>I should be grateful if the following information be provided to me:</u> 1. Confirm whether any steps have or will be taken to address the staffing levels within the Emergency Department or other steps to ensure that there is sufficient capacity to undertake essential duties such as neurological observations.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely **06.09.21**, I, the Coroner, may extend this 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 necessary.

8	**COPIES AND PUBLICATION** I have sent a copy of my report to the Chief Coroner and the following Interested Person (s) • **The family of Valmai Ann WEST** 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 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	**DATE 13/7/21** Signed  Caroline Saunders **Her Majesty's Senior Coroner for the Area of Gwent.**