REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] Director Springbank Nursing Homes, Caring Ltd**
1	**CORONER** I am Christopher John Woolley, Assistant Coroner, for the Coroner area of Cardiff and the Vale of Glamorgan
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 31st July 2013 I commenced an investigation into the death of Sandra Wordingham. The investigation concluded at the end of the inquest on 27th November 2013. The medical cause of death was: 1A Intracerebral Haemorrhage, and the conclusion of the inquest was that the deceased died from natural causes.
4	**CIRCUMSTANCES OF THE DEATH** Sandra Wordingham was a resident at Springbank nursing home, College Road, Barry. She had special needs and suffered from epilepsy. On 22nd July 2013 at around 23.30 hours care assistants found her in an unconscious state. They alerted the qualified nurses who tried to rouse her without success. It was assumed that she had had an epileptic fit and needed to sleep it off. She was put to bed unconscious. At 2.00 am she was checked again and was still unconscious. She was checked at 3.30 am, 5.30 am and 7.15 am and was in the same unconscious state. At 7.15 am paramedics were called who took her to Llandough hospital. She died in hospital on 26th July 2013
5	**CORONER'S CONCERNS** 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. The **MATTERS OF CONCERN** are as follows. – (1) Sandra Wordingham, was put to bed in the nursing home in an unconscious state after a suspected epileptic fit. In fact she had suffered a sudden primary intracerebral haemorrhage. No medical opinion was sought even though Sandra Wordingham remained unconscious throughout the night for a far longer period than would be expected after an epileptic fit. (2) While Sandra Wordingham suffered a profound insult which could not have been altered, had she suffered a gradual onset stroke then intervention could have been offered. In that event early medical attention would have saved her. (3) Residents in an unconscious state who are treated in future in the same way as Sandra Wordingham may be at risk of unnecessary death or injury.

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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 11th February 2014. 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 1. [redacted]. I have also sent it to [redacted], Operations Manager, Caring Limited 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	**17th December 2013** **C J Woolley, Assistant Coroner**