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 ABMU Health Board** **2. [redacted] - Daughter** **3. Chief Coroner** **4. Health Inspectorate Wales**
1	**CORONER** I am Andrew Roger Barkley, Senior Coroner, for the coroner area of Powys, Bridgend and Glamorgan Valleys
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 16th December 2014 I commenced an investigation into the death of Howell Glyndwr Fisher. The investigation was concluded at the end of an inquest on today's date being16th April 2015. The conclusion of the inquest was a narrative conclusion: *"Howell Glyndwr Fisher died from the complications of a fractured hip which he sustained when he fell at his home address on the 5th November 2014, against a background of vascular disease and respiratory problems".*
4	**CIRCUMSTANCES OF THE DEATH** The deceased fell at his home address on the 5th November 2014. He was admitted to the Princess of Wales Hospital where his hip was surgically repaired. Following the surgery he developed an Ischemic left leg and was moved to Morriston Hospital in Swansea for vascular surgery. He was unwell on arrival suffering with Atrial Fibrillation and Pneumonia and Chronic Kidney impairment. He underwent surgery at Morriston which was successful and was then discharged back to the Princess of Wales Hospital on the 20th November. He developed further pneumonia, continued to deteriorate and passed away on the 9th December on ward 6. Whilst at Morriston Hospital he sustained two falls (no injuries sustained) and on transfer back to the Princess of Wales Hospital he sustained a further three falls (only a minor injury received) on the last fall on the 4th December 2014.
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) Within the space of a month the deceased had at least 5 falls whilst being deemed as high risk of falls. He was identified as requiring one to one nursing but there were many occasions when insufficient staff numbers meant that that could not be delivered. (2) There was no "handover material" at the point of transfer between the two hospitals detailing that he was at high risk of falls and further more on readmission to the Princess of Wales Hospital on the 20th November no falls risk assessment was carried out – indeed, after each successive fall in the Princess of Wales Hospital no formal assessment appears to have been undertaken. Throughout he remained at high risk of falls.
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 16th June 2015. 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, the Chief Executive of ABMU Health Board, [redacted] (son) and Health Inspectorate Wales 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	**21st April 2015 SIGNED:**