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. Chief Executive of ABMU Health Board** **2. Minister for Health, Welsh Assembly Government**
1	**CORONER** I am Andrew Roger BARKLEY, Senior Coroner for the coroner area of South Wales Central.
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 23rd September 2016 I commenced an investigation into the death of Edwina Rose Moses aged 78. The investigation was concluded at an end of an inquest dated the 20th December. The conclusion of the inquest was that of a narrative conclusion namely "*Edwina Rose Moses, who suffered from complex health issues and dementia died as a result of an upper gastrointestinal bleed having undergone surgery to repair two broken hips after a fall at her home address and a fall in hospital at a time when she was assessed as requiring one to one care*".
4	**CIRCUMSTANCES OF THE DEATH** The deceased was admitted to hospital on the 15th August having fallen at her home address fracturing her left neck of femur. That was surgically repaired on the 18th August after which, despite some setbacks in terms of respiratory function, she appeared to be making a recovery. She fell from her hospital bed on the 31st August at a time when she should have been receiving one to one nursing care. She fractured her right hip which was surgically repaired the same day. In the following days she became increasingly unwell showing signs of a gastrointestinal bleed and deteriorated and passed away on the 19th September 2016.
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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] 1. The evidence revealed that there was a poor system in place for requesting

	additional nursing cover to provide one to one support. There was confusion by front line staff as to who was responsible for identifying, booking and ensuring that such help was provided. 2. The evidence showed that it was common place for additional nursing cover not to attend and staff were then left to provide one to one cover alongside their main stream duties – which was wholly unrealistic. Given the apparent frequence in which additional nursing cover is "unavailable", often in the context of dealing with patients suffering with dementia, the issue of appropriate staffing levels on wards and the ability of staff to safely look after patients must be a concern.
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 15th February 2017. 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 [redacted] 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	**SIGNED:** **Dated:** 22/12/16