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 the Cardiff and the Vale University Health Board** 2. **Minister for Health Welsh Assembly Government** 3. **Chief Coroner** 4. [redacted]
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 20th June 2016 I commenced an investigation into the death of Maurice ISAACS. The investigation concluded at the end of the inquest on the 2nd November 2016. The conclusion of the inquest was that of a narrative conclusion:- "*Maurice ISAACS died from the effects of a traumatic head injury which he sustained when he suffered one of eight falls whilst in hospital, against a background of dementia, declining health and frailty*"
4	**CIRCUMSTANCES OF THE DEATH** The deceased suffered from Dementia, Chronic Obstructive Pulmonary Disease and Chronic Kidney Disease and was cared for in his own home by his daughter. When she could no longer manage his care, after a significant deterioration in his condition, he was admitted to hospital acutely on 27th April 2016. On admission he was deemed to be at high risk of falls. Whist in hospital he fell on seven separate occasions. He was known to suffer from dementia, and at times was delirium. He was particularly restless and agitated during the night time. In the early hours of 12th June 2016 he fell from his bed and was found on the floor and was believed to have suffered a head injury. After complaining of a headache and after a fall in his level of consciousness, a CT scan revealed a bleed on the brain. He continued to deteriorate and died two days later.
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 investigation into his death revealed shortcomings in the way in which his risk of falls were assessed and recorded. For example, no clear care plan was introduced until after the fourth fall. Although there were some occasions when he was given 1:1 care that was not consistent and despite the increasing number of falls, he was never given true 1:1 supervision / observation. Despite the medical notes showing that this should have been in place at the time of his final fall, the reality on the ward was that he was being observed by a nurse on a 1:4 basis. Despite the ward being staffed to "agreed staffing levels" the evidence showed that on the ground, on occasions, this was simply not enough staff to manage the demands of the ward. His condition was so variable and unpredictable, and against a background of so many falls, 1:1 care was indicated. The evidence showed that whilst there was a review of his situation after each fall, a more "holistic" approach, recognising the dangers posed by his unpredictable behaviour, and the causes of that, might have prevented so many falls. (2) After the final fall, shortcomings were identified in the way that the standard "Neuro Observations" were carried out. They were not carried out in line with Trust Policy. They were conducted by a Health Care Assistant, who had not been trained and who failed to conduct one part of the test for a period of six hours. The omission was not spotted by the qualified nurse whose duty it was to oversee the work of the Healthcare Assistant.
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 28 December 2016 . 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 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:  Mr Andrew Barkley HM Senior Coroner 7th November 2016