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 of the Cwm Taf University Health Board** **2. Minister of Health, Welsh Assembly Government** **3. The Chief Coroner**
1	**CORONER** I am Andrew 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 7th September 2016 I commenced an investigation into the death of Clive Davies. The investigation concluded at the end of an inquest on the 15th March 2017. The conclusion of the inquest was that of a narrative conclusion *"Clive Davies died from the complication of a head and neck injury which he sustained when he fell down the stairs at his home address. The precise cause of the fall is unknown but is likely to have been due to the medical condition which he suffered with."*
4	**CIRCUMSTANCES OF THE DEATH** The deceased, who was known to have fallen several times since January 2016 and who was generally in poor health, fell down the stairs at his home address on the 22nd August 2016 he was conveyed to the Royal Glamorgan Hospital where a CT scan revealed serious head injury (Intraventricular Haemorrhage) and a Cervical Spine Fracture. Initially his observations were stable but a noticeable deterioration occurred on the 24th August where upon a further CT head scan took place which revealed progression of the intracranial bleed. He was not deemed suitable for surgical intervention. His condition fluctuated and he appeared to be making some progress although his family maintained that he was deteriorating throughout his hospital admission. In the early of 30th August he was found unresponsive in his bed and could not be revived. He was declared deceased shortly after.
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 as follows The **MATTERS OF CONCERN** are as follows. – [BRIEF SUMMARY OF MATTERS OF CONCERN]

	(1) The evidence revealed that there were generalised failures in relation to routine observations conducted upon Mr Davies – both NEWS observations and "neuro" observations. On the 29th August neuro observations were performed at 0600 hours but were then supposed to be conducted every 4 hours but were not at 10AM 2PM 6PM and 10PM. The final neuro observation was conducted at 11PM and no explanation could be found as to why this had not happened. The last NEWS score was conducted at 1745 on the 29th August but not thereafter. Upon review it appeared that that NEWS score which was undertaken was incorrectly calculated meaning that he was not subject to a medical review when clearly he should have been. It was accepted at the inquest that this was a failure for which no explanation was forthcoming.
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 7th June 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, the Health Minister of the Welsh Assembly Government and the family 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	**16th March 2017** **SIGNED:** **Mr Andrew Barkley** **HM Senior Coroner**