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 Cwm Taff University Health Board**
1	**CORONER** I am Graeme Hughes, Assistant Coroner, for the coroner area of South Wales Central Area.
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 21st September 2017 I commenced an investigation into the death of Howard Winter aged 85. The investigation concluded at the end of an inquest on 1st February 2018. The medical cause of death was 1a. Hospital Acquired Pneumonia, 1b C5-6 vertebral fracture with cord injury, alongside subdural bleeding in the setting of a person with ankylosing spondylitis, 1c Recurrent Falls & 2. Vascular Dementia. The conclusion of the inquest was Accidental Death.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was a resident at the Daffodils CH, Merthyr Tydfil. He suffered from vascular dementia & had frequent falls. On 23.8.17 he fell in his room, sustained a serious head injury & was taken to PCH, Merthyr Tydfil. On 11.9.17 he was diagnosed with a fractured spine. He developed pneumonia & died there on 16.9.17
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. – When Mr Winter attended at A & E on 23 & 26.8.17, he was diagnosed with a subdural haematoma following a CT scan head. It was not until after a CT scan of his spine was undertaken on 11.9.17 that he was diagnosed with a cervical spine fracture. The question arose as to whether, & following his initial presentation on 23.9.17 & admission on 26.8.17 there was any evidence of symptoms of neck pain which could have given rise to earlier investigations into, & possible earlier diagnosis of the cervical spine fracture. [redacted] gave evidence at the Inquest that on the 26.8.17 an auxiliary nurse had recorded in the nursing notes – "pain in neck/back – unable to score". There was no evidence – written or otherwise, to demonstrate an escalation of this finding to a doctor

	for re-assessment, investigation & diagnosis. [redacted] evidence to the Inquest was that this ought to have occurred. Whilst this apparent absence of escalation may not necessarily have affected the outcome for Mr Winter, were it to be repeated now, or in the future, the outcome for the patient involved could be potentially causative of/contribute towards death/adverse outcome.
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 5th March 2018. 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 family and the Minister of Health Welsh Government Assembly 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	**8th February 2018** **SIGNED:**