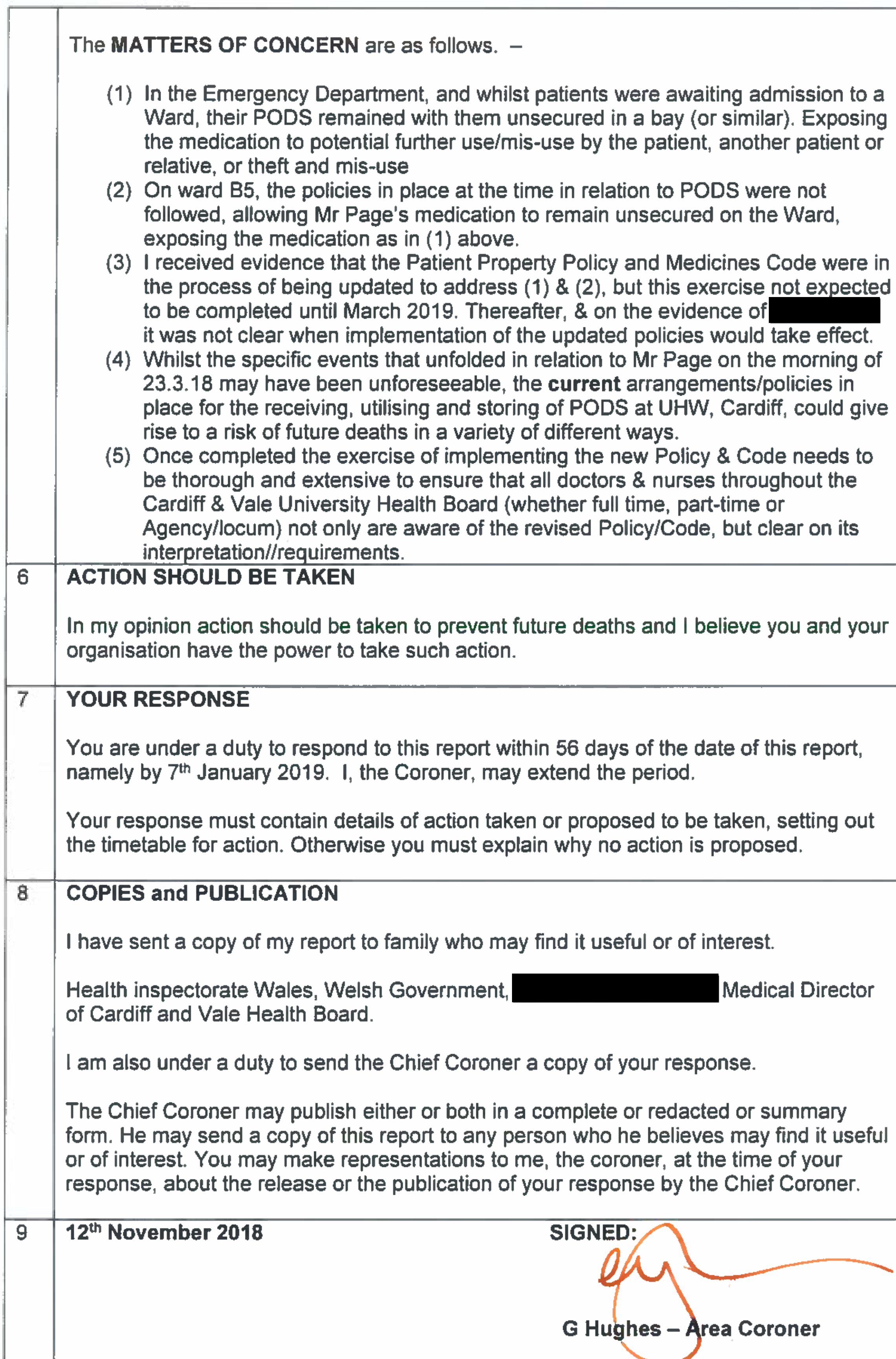
ANNEX A

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:** **The Chief Executive Cardiff & Vale University Health Board**
1	**CORONER** I am Graeme Hughes, Area 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** I commenced an investigation on the 28th March 2018 into the death of Joseph Page. The Investigation concluded at the end of the inquest on 5th November 2018. The conclusion was "Suicide" and the medical cause of death was 1a. Multi-Organ Failure 1b. Hypotension 1c. Mixed Drug Toxicity
4	**CIRCUMSTANCES OF THE DEATH** These were recorded as :- Joseph Page had a number of significant co-morbidities, most notably chronic kidney disease and ischaemic cardiomyopathy. He was experiencing declining health, which led to him being admitted to University Hospital Wales on 15.3.18. He was responding well to treatment, when, and on 22.3.18, he received some upsetting news in relation to the health of one of his daughters. At, or around 1.45am on 23.3.18 he has deliberately taken a mixed overdose of his prescription medication. That medication was accessible to him, & not locked away in his bedside medicine cupboard contravening the hospital's Medicines Code & patient property policies. Despite treatment thereafter he declined significantly from around 8am, and likely suffered multi-organ failure, consequent upon hypotension and overdose. He died at around 9.30am that day. The Inquest focused upon:- a. The practices & procedures in place at University Hospital Wales Cardiff – both in the Emergency Department and Ward B5 for receiving, utilising & storing Patients Own Drugs (PODS) whilst in hospital b. The treatment received by Mr Page post overdose .
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) In the Emergency Department, and whilst patients were awaiting admission to a Ward, their PODS remained with them unsecured in a bay (or similar). Exposing the medication to potential further use/mis-use by the patient, another patient or relative, or theft and mis-use (2) On ward B5, the policies in place at the time in relation to PODS were not followed, allowing Mr Page's medication to remain unsecured on the Ward, exposing the medication as in (1) above. (3) I received evidence that the Patient Property Policy and Medicines Code were in the process of being updated to address (1) & (2), but this exercise not expected to be completed until March 2019. Thereafter, & on the evidence of ████ it was not clear when implementation of the updated policies would take effect. (4) Whilst the specific events that unfolded in relation to Mr Page on the morning of 23.3.18 may have been unforeseeable, the **current** arrangements/policies in place for the receiving, utilising and storing of PODS at UHW, Cardiff, could give rise to a risk of future deaths in a variety of different ways. (5) Once completed the exercise of implementing the new Policy & Code needs to be thorough and extensive to ensure that all doctors & nurses throughout the Cardiff & Vale University Health Board (whether full time, part-time or Agency/locum) not only are aware of the revised Policy/Code, but clear on its interpretation//requirements.
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 January 2019. 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 family who may find it useful or of interest. Health inspectorate Wales, Welsh Government, ████ Medical Director of Cardiff and Vale Health Board. 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	**12th November 2018** **SIGNED:** **G Hughes – Area Coroner**