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:** **Chief Executive, Cardiff and Vale University Health Board** **Chief Executive, Cwm Taf Morgannwg University Health Board** **Chief Executive, Swansea Bay University Health Board** **Chief Executive, Powys Teaching Health Board** **Chief Executive, Hwyel Dda University Health Board** **Vaughan Gething, Health Minister, Welsh Assembly Government**
1	**CORONER** I am Rachel Knight, Assistant 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. **I AM SENDING THIS REPORT TO FIVE SEPARATE HEALTH BOARDS, BUT I WISH TO RECEIVE A COLLABORATIVE SINGLE RESPONSE SETTING OUT A PROPOSAL FOR A NEW SYSTEM OF REFERRALS. THIS PROPOSAL MUST BEST FIT ALL BOARDS, SINCE THERE ARE A VAST NUMBER OF OUTLYING UNITS WHICH RELY UPON ON NEUROLOGY AT UHW FOR ASSISTANCE.** **A further response is also expected from the Welsh Assembly Government, since there may be budgetary implications.**
3	**INVESTIGATION and INQUEST** On the 8th November 2018 an inquest was opened into the death of Glenys Button. The investigation was concluded at a hearing on the 6th June 2019. The conclusion was that Mrs Button had suffered an accidental death, following a fall backwards onto a wooden floor at home.

4	**CIRCUMSTANCES OF THE DEATH** Glenys Button was aged 78 on the 5th November 2018 when she died at the Royal Glamorgan Hospital. She had sustained a head injury involving a basal skull fracture and an unusual pneumocephalus and brain bleed, following a likely accidental backwards fall onto a wooden floor at her home address on 2nd November 2018. She had a number of co-morbidities including ischaemic heart disease, diabetes, osteoarthritis and chronic obstructive pulmonary disease. There is no neurosurgery ward at the Royal Glamorgan Hospital, therefore trauma doctors there (and similarly in other outlying units throughout South and West Wales) rely heavily upon emergency advice from the on-call neurosurgeons at the University Hospital of Wales in Cardiff as to the treatment and management of head and brain injury patients such as Mrs Button. It is the neurosurgeons who make the final decision as to whether to transfer the patient to the UHW for intervention. In this case, there were frustrating delays in contacting the on-call neurosurgery specialist registrar, there was confusion over whether Mrs Button was a suitable candidate for transfer to the unit in Cardiff for treatment, there was conflict over the discussion of her co-morbidities and there was inadequate written evidence of the various conversations. Following a deterioration in her condition, Mrs Button was firstly accepted, then rejected for transfer to Cardiff (mid-journey) and was ultimately managed conservatively on a trauma and orthopaedics ward at the RGH, where she succumbed to her devastating injuries.
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) There are a high number of referrals to the single rota'd on-call neurosurgical specialist registrar every day. The system for making and receiving the referrals is not fit for purpose, with inefficient delays, miscommunications and confusion occurring. The use of the UHW switchboard and bleeping the doctor is archaic, and does not utilise technology as it should. Further, if the on-call doctor is in surgery or dealing with an emergency, there is no back up doctor to field the referrals, which can often be time critical. (2) There is a similar situation with spinal specialists, where Cardiff has the experts and the outlying hospitals contact them for advice. A pro forma document has been designed which is filled in by local doctors and sent

	to a generic email address for the spinal team. The pro forma is considered and completed by the specialists and emailed back with answers. The only telephone call (to a direct number rather than the switchboard) involves the outlying hospital notifying the spinal team to expect an email referral. This system reduces the risk of delay and miscommunication, and provides a single, collaborative document for a patient's notes. Could this be a better system to be used with neurosurgery referrals as a short-term measure? (3) There is a cutting-edge system used in Bristol, in Southmead Hospital, called www.referapatient.org which uses modern technology to assist in referring patients between departments/hospitals. The website is self-explanatory. Could this be a better system to be used widely across the NHS in Wales in the longer term?
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 112 days of the date of this report (double the usual response time, given the wide nature of this report), namely by 30th September 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: • the family of Mrs Button; • [redacted] at the Royal Glamorgan Hospital; • [redacted] at the Royal Glamorgan Hospital; • [redacted] Hayhurst at the University Hospital of Wales; and • [redacted] at Southmead Hospital 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	**10th June 2019**	**SIGNED:**  **Rachel Knight** **Assistant Coroner**