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 Cwm Taf Morgannwg University Health Board**
1	**CORONER** I am Graeme Hughes, Acting 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 14th February 2017 I commenced an investigation into the death of Annette Susan HEWINS. The investigation concluded at the end of the inquest on 19.9.19. The conclusion of the inquest was The deceased likely died as a consequence of a fatal arrhythmia against a background of undiagnosed, asymptomatic heart disease. It is likely that this occurred as a consequence of the psychological and physiological stresses necessarily imposed upon her by her acute psychosis, opiate withdrawal and admission to hospital. It is possible, but not probable, that medication administered to her to treat her acute symptoms may have had some role to play in the development of the arrhythmia.
4	**CIRCUMSTANCES OF THE DEATH** These were recorded as :- On 7.2.17 Annette Hewins was detained under section 2 Mental Health Act 1983 following concerns over psychotic symptoms and opiate withdrawal. She was admitted to the Royal Glamorgan Hospital for a period of assessment and treatment. Her agitated condition fluctuated during admission, and she was treated symptomatically. On 8.2.17 at around 16:45 she was discovered unconscious in her room. Despite cardio pulmonary resuscitation she died at 17:15. A post mortem examination posthumously revealed extensive coronary artery atherosclerosis as the likely cause of death. The Inquest broadly focused upon:- a. Ms Hewins's admission to hospital on 7.2.17. b. Her treatment thereafter c. Her physical health monitoring & observations d. Any role the administration of certain medications played in her death e. Any role clinical decisions may have played in her death f. Practices & procedures in place for the management of acute opiate withdrawal g. The cause of her death
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 appeared to be some inconsistency as to approach to be taken amongst the Nursing staff/Health Care Assistants as to when entries should be made in the FACE records following interaction with a patient. It is considered that some guidance/training on this issue would be of benefit to promote greater consistency (2) Erroneously completed NEWS charts – it transpired that Nursing Staff/HCA's were using the frequency of observation box, to record the time observations were carried out. This may require guidance/training to remind staff completing the NEWS charts of the importance of ensuring the appropriate boxes are completed. (3) Missed Observations – It transpired that NEWS observations ought to have been undertaken at around 7.30am on 8.2.17. There was no record that they had. Whilst there appeared to be systems in place to prompt Nurses/HCA's to undertake the observations on time – enhanced observations recorded on a white board & the NEWS charts of those patients receiving enhanced observations being separated on the Nursing station, these did not achieve the desired outcome here. It is suggested that more robust (possibly linked to FACE) procedures should be considered to ensure the observations are performed on time (4) ECG Requests – [redacted] plan on 8.2.17 was for an ECG to be undertaken. There was no evidence that it had, or had been requested – not documented. The system in place for requesting ECG's – routine or otherwise appeared somewhat *ad hoc* and it is suggested that a more robust system for documenting & requesting ECG's should be considered & implemented. (5) It was considered that some of the detail provided by Nurses/HCA's when completing the 15 minute observations chart was inadequate. In particular entries such as "bed". It was accepted that such information was inadequate & a brief addendum adding the condition of the patient was desirable – i.e. recording not simply *where* a patient was located at the time, but also their state – *calm, agitated, sleeping*, etc. It was felt that guidance/training on the appropriate completion of these observation charts was indicated, so that patterns of physical & mental health symptoms could be assessed. (6) Consideration should be given to the creation & use of a policy within the Trust for managing opiate dependant patients in the acute admission setting. Whilst the absence of such a policy is unlikely to have altered the outcome here, it was agreed by the Head of Mental Health Nursing that such a policy would be worthy of consideration, to assist clinicians & nurses faced with treating such patients. Such policies are in place in the Aneurin Bevan UHB & C & V UHB, as well as several HB's in England
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 19th November 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.

	Healthcare Inspectorate Wales, Welsh Government 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	24th September 2019 **SIGNED:**  Graeme Hughes, Acting Senior Coroner for **South Wales Central**