GRAEME HUGHES

HIS MAJESTY'S SENIOR CORONER

SOUTH WALES CENTRAL CORONER AREA

CORONER'S OFFICE
THE OLD COURTHOUSE
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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 **Gaynor Kynaston 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.
3	**INVESTIGATION and INQUEST** On 5 December 2022 I commenced an investigation into the death of John Austin FOLLON . The investigation concluded at the end of the inquest 08/10/2024 . The conclusion of the inquest was Mr John Follon, a 78year old gentleman was admitted to hospital from the GP surgery having suffered a MI. He underwent successful stenting to remove the blockage. Four days later, he suffered a cardiac arrest from which he did not recover. Prior to the cardiac event, a lead from the monitor had become disconnected, the alarm was silenced by a staff member who did not then check on Mr Follon leading to a period of an hour and three quarters during which he was not monitored. The cause of the cardiac arrest cannot be established and it is not possible to determine whether the lack of monitoring more than minimally contributed to his death.. **1a Inferior ST Elevation Myocardial Infarction**

	1b **1c** **II Hypertension, Chronic Smoker**
4	**CIRCUMSTANCES OF THE DEATH** Mr John Follon, a 78 year old gentleman attended his GP surgery with chest pains and breathlessness on 17 Nov 2022. Following an ECG, which showed he had suffered an inferior myocardial infarction, he was transported by emergency ambulance from the surgery directly to the catheter laboratory at The University Hospital of Wales where he underwent a stenting procedure to unblock the right coronary artery. He made good progress following the procedure to the point of independently caring for himself on the ward. However, the monitor showed intermittent 1st degree and complete heart block and a decision on whether he required a permanent pacemaker depended upon the extent of his recovery. While awaiting this decision, he was being monitored on CCU by telemetry. On 21 Nov 2022 at 06:57, one of the leads became disconnected triggering an alarm at the nurses station which was acknowledged at 07:04 and silenced by a staff member. The evidence suggests that person did not check on Mr Follon at that time. Mr Follon was last spoken to on or around 07:30hours before being found unresponsive in a state of cardiac arrest in his bed at 08:45hrs. Resuscitation was commenced, however, it was not successful and he passed away at 09:06. Neither the cause nor time of the cardiac arrest can be established as he there was no monitoring during the period from when the lead became detached until his death.
5	**<u>CORONER'S CONCERNS</u>** 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) Changes to the alarm system have been made following Mr Follon's death such as making the alarm louder and ensuring a yellow ribbon appears and remains at the top of the monitoring screen until the alarm is reactivated. However, it is still possible for a member of staff to silence the alarm without checking on the patient and the alarm will remain silent until it is physically reactivated by a member of staff. (2) Currently when the alarm is triggered, during the day shift, staff are required to check on the patient prior to the alarm being silenced, during a night shift staff are permitted to silence the alarm prior to checking the patient to reduce noise to a minimum while patients are sleeping. The latter was the position in the instant case when Mr Follon's lead became detached. (3) The monitors are not checked constantly or even every hour but are checked twice during each shift. During a busy night shift or during handover, if the person silencing the alarm does not attend to the patient at the time the alarm sounds and if the amber ribbon, which now appears on the monitor alerting staff to a "lead off" scenario, goes unnoticed, the risk that a patient will not be monitored for a significant period of time remains.

	(4) During a night shift, the circumstances in which Mr Follon died remain the same notwithstanding changes to nursing practice and the alarm system have been made. The risk of a patient not being monitored for a significant period of time remains and could give rise to a death in similar circumstances in the future.
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 8th December 2024 only 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** Chief Executive Officer, [redacted], Cardiff and Vale University Local Health Board I have sent a copy of my report to 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	14 October 2024 **SIGNED:**  Gaynor Kynaston Assistant Coroner for South Wales Central Coroner Area