GRAEME HUGHES

HIS MAJESTY'S SENIOR CORONER

SOUTH WALES CENTRAL CORONER AREA

CORONER'S OFFICE
THE OLD COURTHOUSE
COURTHOUSE STREET
PONTYPRIDD
CF37 1JW

Telephone: [redacted]
Email: [redacted]

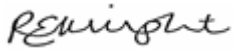
ANNEX A

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 **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.
3	**INVESTIGATION and INQUEST** On 24 October 2023 I commenced an investigation into the death of Colin Colley. The investigation concluded at the end of the inquest on 12th March 2025. The conclusion of the inquest was a narrative: Colin Colley was aged 87 when on 14th October 2023 he died at the University Hospital of Wales, Cardiff. Colin suffered with a number of comorbidities including dementia and frailty, and he was anticoagulated for atrial fibrillation. Colin suffered an unwitnessed fall from bed on 11th October, when he was an inpatient at St. David's Hospital, Cardiff. He was known to wander from his bed in hospital, and had fallen previously, and he had been assessed as being at high risk of falls. His restlessness and cognitive decline indicated that his cot sides should have been left down. He had been assessed as requiring one-to-one supervision. At the time of Colin's final fall, he had been left unsupervised and bed rails were in place, in error. He sustained a fatal brain bleed, and was transferred to the University Hospital of Wales, where sadly his condition deteriorated until his death.

	1a Intracranial haemorrhage **1b Unwitnessed fall with traumatic head injury** **1c Vascular dementia, frailty of old age** **II Atrial fibrillation (treated)**
4	**CIRCUMSTANCES OF THE DEATH** Mr Colley was left unsupervised with cot sides up. He climbed out and fell sustaining a fatal head injury. He should not have been left unsupervised and his cot sides should not have been up. The Inquest focused upon:- a. Mr Colley's risk of falling; and b. The use of the Enhanced Supervision Document;.
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) Evidence was taken from nurses at St David's that there remains a lack of confidence in both qualified nursing staff, healthcare assistants and healthcare support workers in the use of and implication of risk assessments around falls, and the use of and importance of enhanced supervision and the Enhanced Supervision Document. I am concerned that unless more training is provided and refreshed frequently, there is a risk of future deaths occurring, particularly given the cohort being nursed at that hospital and the turnover of staff.
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 May 2025. 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. 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	13 March 2025  **SIGNED:** Rachel Knight Assistant Coroner for South Wales Central Coroner Area