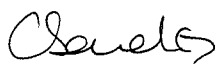
Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. Chief Executive, Aneurin Bevan University Health board
1	**CORONER** I am **Caroline Saunders,** Senior Coroner for the Area of Gwent
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 **31/10/19** an investigation was opened into the death of **Elizabeth Joyce ROBINSON** The investigation concluded at the end of the inquest on: **4/3/21** The conclusion of the inquest was recorded as: **Death By Accident** The medical cause of death was: 1a) Subdural haemorrhage with subfalcine herniation. 1b) In patient fall sustaining head trauma. 1c 2 Cognitive impairment, Coronary artery bypass graft, aortic dissection with repair.
4	**CIRCUMSTANCES OF THE DEATH** Elizabeth Robinson was an 87-year-old lady who had led an active and independent life until early 2019 when she seemed to develop signs of dementia. On 17th July 2019 she sustained a fractured hip and was admitted to Prince Charles Hospital where she underwent surgery. On 6th September 2019 Mrs Robinson was transferred to Ysbyty Ystrad Fawr (YYF) for ongoing rehabilitation.

	Mrs Robinson was at high risk of falls and at approximately 02:30 hours on 21st October 2019, Mrs Robinson got out of bed, fell and hit her head sustaining a fatal head injury. Mrs Robinson was kept under observation but deteriorated rapidly at 06:30 hours when she was discovered to be unresponsive. A CT scan at that time confirmed an extensive cerebral bleed and sadly she died later that day at 17:30 hours
5	**CORONER'S CONCERNS** During the course of the inquest, 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. <u>Staffing Levels</u> Aneurin Bevan University Health Board undertook an internal investigation which was presented at the inquest by [redacted] confirmed that Mrs Robinson had not been correctly assessed and warranted a higher level of supervision to minimise the risk of her falling. Whilst the documentation was not completed, two nurses gave evidence and I was reassured that they both understood that Mrs Robinson was at high risk of falls and were monitoring her as closely as possible with the staffing complement available. I was informed that on the ward at YYF there were usually 3 members of nursing staff to care for 15 patients. Mrs Robinson was in a cohorted group which meant that 1 member of staff was assigned to observe a group of 4 patients at all times. This left 2 nurses for the remaining 11 patients. The nurses who gave evidence both told me that they rarely managed to get their full breaks (40 minutes in a 12 hour shift) and were constantly in a position where they did not feel they could deliver a safe standard of care to the patients. Mrs Rowlands confirmed that staffing levels were not considered during the investigation and it was further confirmed that these apparently low staffing levels still exist. 2. <u>Serious Concerns report findings</u> At the inquest, Mrs Rowlands described the omissions in the falls risk assessment process and the steps that are now being taken to ensure that staff complete the documentation properly. It is my understanding that the internal investigation is an essential component of organisational learning to improve the quality of care to patients and also prevent future deaths. Mrs Rowlands informed me that falls were the greatest risk posed to patients by

	the Health Board. I was therefore concerned to hear that neither of the nursing staff who gave evidence had seen the findings of the internal investigation some 1 years and 4 months since Mrs Robinson's death.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. <u>I should be grateful if the following information be provided to me:</u> 1. Confirm whether any steps have or will be taken to address the staffing levels on Oakdale Ward at YYF. 2. Describe how the findings and learning from the internal investigations are shared in a meaningful and timely manner with all grades of clinical staff.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely I, the Coroner, may extend this 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 necessary
8	**COPIES AND PUBLICATION** I have sent a copy of my report to the Chief Coroner and the following Interested Person (s) . The family of Elizabeth Robinson 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 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	**DATE 12/3/21** Signed  Caroline Saunders **Her Majesty's Senior Coroner for the Area of Gwent.**