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:** **1.** [redacted] Senior Partner at Alexander House Health Centre, Platt Bridge Health Centre, Rivington Avenue, Platt Bridge, Wigan
1	**CORONER** I am Rachael Clare Griffin, Assistant Coroner, for the Coroner Area of Manchester West
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 the 18th June 2015 I commenced an investigation into the death of Dorothy Delaney, born on the 20th July 1928. The investigation concluded at the end of the inquest on the 18th September 2015. The Medical Cause of Death was: 1a Spontaneous Intracerebral Haemorrhage 1b Amyloid Angiopathy 2 Anti Coagulation, Atrial Fibrillation The conclusion of the inquest was that Dorothy Delaney died as a consequence of naturally occurring disease exacerbated by a recognised complication of anticoagulation therapy, in circumstances where antiplatelet medication was prescribed and administered.
4	**CIRCUMSTANCES OF THE DEATH** At around 10.20 hours on the 11th June 2015 Mrs Dorothy Delaney, who had been prescribed Rivoroxaban, an anticoagulant, following her diagnosis of atrial fibrillation in March 2015, and who was prescribed Clopidogrel, an antiplatelet medication due to previous transient ischaemic attacks, was found in a collapsed condition at her home address at Ash Tree House Care Home, Warwick Drive, Hindley in Wigan. She was transferred to the Salford Royal Hospital, Salford where she was diagnosed as having suffered a large intracerebral haemorrhage. Her condition deteriorated and she died later that day at 13.10 hours.

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. During the inquest evidence was heard that: i. Dorothy Delaney became a patient at Alexander House Health Centre, Platt Bridge Health Centre, Rivington Avenue, Platt Bridge, Wigan in August 2013. At that time she was prescribed Clopidogrel, an antiplatelet medication, by her previous general practitioner, due to her history of transient ischaemic attack. This prescription continued to be given by her general practitioner at Alexander House Health Centre up until her death on the 11th June 2015. ii. In March 2015 Mrs Delaney was diagnosed with atrial fibrillation and as a result was prescribed Rivoroxaban, an anticoagulant, by her general practitioner at Alexander House Health Centre, which she continued to take up until her death. iii. The Consultant Neuropathologist gave evidence during the inquest that Mrs Delaney had died as a consequence of a spontaneous intracerebral haemorrhage which had been caused by amyloid angiopathy, which is naturally occurring disease of the vessels within the brain that can cause the vessels to rupture, resulting in haemorrhage. Evidence was given that when a person who suffers from amyloid angiopathy takes anticoagulation medication there is an enhanced risk of a haemorrhage occurring. The fact that Mrs Delaney was taking Rivoroxaban was determined to be a contributory factor in her death. Evidence was also given that there is an increased risk of bleeding when a person takes both antiplatelet and anticoagulant medication together. iv. The policy adopted at Salford Royal Hospital, Salford is that if a person who is prescribed antiplatelet medication requires anticoagulation therapy, they would discontinue one of the medications, in order to reduce the risk of a haemorrhage, unless there is a specific reason why both should be prescribed at the same time. v. Guidance provided by the National Institute for Health and Care for oral anticoagulation was referred to during the inquest and this guidance states that if a person is prescribed Rivoroxaban there is an increased risk of bleeding if anti platelet medication, such as Clopidogrel, it is taken at the same time. The Guidance states that the use of both medications should be avoided, except on specialist advice. vi. Following Mrs Delaney's diagnosis of atrial fibrillation and the subsequent prescription of Rivoroxaban, no specialist advice was sought regarding the appropriateness of continuing to prescribe

	both Clopidogrel and Rivoroxaban together. Evidence was given at the inquest that advice is not sought on an individual basis for patients at Alexander House Health Centre who are prescribed both Clopidogrel and Rivoroxaban as they rely on advice previously sought in respect of other patients in similar circumstances. 2. I therefore have concerns that there are patients under the care of Alexander House Health Centre who are being prescribed both anticoagulation therapy and antiplatelet medication at the same time, which increases the risk of a haemorrhage occurring, in circumstances where specialist advice has not been sought, taking into account the individual patient's previous medical history and circumstances. 3. I therefore request [redacted] review the treatment of all patients in his practice who are being treated with Clopidogrel, or any other antiplatelet medication at the same time as Rivoroxaban, or any other anticoagulation medication, having regard to the NICE guidelines in relation to oral anticoagulation.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe you and/or 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, 18th November 2015. 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 Chief Coroner and to the following Interested Persons: (1) [redacted], Dorothy Delaney's son on behalf of the family (2) Wigan Borough Clinical Commissioning Group, Wigan Life Centre, College Avenue, Wigan, WN1 1NJ 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	**Dated** **23rd September 2015** **Signed** **Rachael C Griffin**