REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Mark Drakeford AM, Minister of Health, Welsh Assembly Government** **2. Dr Andrew Goodall, Chief Executive, NHS Wales**
1	**CORONER** I am Christopher John Woolley, Assistant Coroner, for the Coroner area of Cardiff and the Vale of Glamorgan
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 6 March 2014 I commenced an investigation into the death of Kathleen Ludmila Neville, aged 93. The investigation concluded at the end of the inquest on 30th July 2015. The medical cause of death was: 1A Bilateral Pneumonia and 1B Fractured neck of femur (operated). I gave a narrative conclusion as follows "Kathleen Ludmila Neville died from the recognised complications of necessary medical intervention and post-operative care, following a prolonged hospital stay after accidentally fracturing her hip and undergoing a left hip hemiarthroplasty."
4	**CIRCUMSTANCES OF THE DEATH** Kathleen Ludmila Neville was admitted to University Hospital of Wales Cardiff on 28th November 2013 after an accidental fall at home in which she had fractured the neck of her femur. The admitting doctor failed to record her regular thyroid medication (Levothyroxine) on the drug chart and the error was not picked up in the primary pharmacy review. The University Hospital of Wales did not have a Medication Reconciliation Policy in place at the time, even though the NICE guidelines from 2007 had recommended such a policy. As a result of this prescription error Kathleen Neville was not given her thyroid medication for a period of five weeks from admission until 8th January 2014. I found that the omission of this medication would have contributed to her lassitude and confusion over the period from 12th December 2013 until 22nd January 2014, but that it did not contribute to her eventual death on the 3rd March 2014.
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) The absence of a Medication Reconciliation Policy at the University Hospital of Wales over the relevant period made it much harder for the individual failures of the admitting doctor and initial pharmacist to be picked up. As a consequence Kathleen Neville was deprived of her medication for a much longer period than would otherwise

	have been the case. (2) While the Coroner found in this inquest that the omission of Levothyroxine did not contribute to the eventual outcome, the position would have been far different in the case of other drugs where omission of medication might well lead directly to death (e.g. insulin). In such cases the absence of a Medication Reconciliation Policy to assist in picking up individual failures could well lead to future deaths. The Coroner found that any system that relies solely on individual human excellence without a supporting policy is eventually bound to fail through individual human error. (3) The Cardiff & Vale University Health Board has now introduced a Medication Reconciliation Policy as recommended by the NICE Guidelines (now updated). The Coroner was satisfied that this was chiefly because of the death of Kathleen Neville. The Coroner was satisfied that University Hospital of Wales and the Cardiff & Vale University Health Board have taken appropriate remedial action. (4) The Coroner is concerned that there may be other Health Boards across Wales that have still not adopted a Medication Reconciliation Policy as recommended by NICE. Future lives may be lost if a Health Board does not have such a policy and similar prescription errors are made. The Coroner is concerned that all Health Boards across Wales should learn the lessons of this inquest and have a Medication Reconciliation Policy in place to prevent future deaths in similar circumstances.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 2nd October 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] 2. [redacted] I have also sent a copy to [redacted] Healthcare Quality Division, Welsh Assembly Government and to the Chief Executive of Cardiff & Vale University Health Board 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	**7th August 2015** **C J Woolley, Assistant Coroner**