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:** **1. His Honour Judge Peter Thornton QC, Chief Coroner of England and Wales.** **2. Mr. Mark Drakeford, Minister for Health, National Assembly for Wales.** **3. Mrs. Allison Williams, Chief Executive, Cwm Taf University Health Board** **4. [redacted] General Medical Practitioner & Partner, The Lawn Medical Practice, Rhymney.** **5. [redacted] Primary Clinical Director Aneurin Bevan University Health Board, Division of Primary Care & Networks.** **6. [redacted], Consultant Psychiatrist, North Community Mental Health Team.** **7. [redacted]**
1	**CORONER** I am Dr. Sarah-Jane Richards, Assistant Coroner, for the coroner area of Powys, Bridgend and Glamorgan Valleys
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 27th March, 2015 I commenced an investigation into the death of Mr. Alun Walters. The investigation concluded at the end of the inquest on the 26th June, 2015. The conclusion of the inquest was '*A gastro-intestinal haemorrhage in the circumstance of suspected elevated levels of Warfarin and failed INR monitoring*'.
4	**CIRCUMSTANCES OF THE DEATH** Mr. Alun Walters had longstanding mental health difficulties and alcohol misuse for which he was receiving community psychiatric support. He had been prescribed Warfarin as an anticoagulation therapy since 2011 following the receipt of a metallic heart valve. Mr. Walters was aware of the need for regular INR testing. He joined the Lawn Medical Practice in 2012 and received weekly Warfarin prescriptions from the Practice. The Practice was contracted by the Aneurin Bevan University Health Board to provide INR testing, dosing and prescriptions. Regular INR tests were undertaken until November 2013. In December 2013 Mr. Walters failed to attend for his routine INR test which triggered contact by the Practice advising him to continue his INR testing. No further tests were actually undertaken by the Practice although his prescriptions continued. In January, 2015 [redacted], the Practice's Health Care Assistance, happened

	to see Mr. Walters in town. She noted that she had an INR test at the Practice since November 2013 and immediately alerted [redacted] GP. In consequence, Mr. Walters was contacted by [redacted] on 30th January, 2015 advising that he urgently needed to attend for INR testing or GP consultation. On 29th January, 2015 the GP Practice's computer prescription data base for Mr. Walters noted that Warfarin was discontinued. A total of 51 prescriptions had been provided to Mr. Walters without the benefit of dosage assessment following INR testing. Pharmacist, [redacted] of the Rhymney Pharmacy Ltd. noted that Warfarin, a longstanding prescription for Mr. Walters, had been dropped from Mr. Walter's prescription list. Believing this to be an error, he continued to provide it. The GP Practice had not notified the Pharmacy that Mr. Walter's longstanding prescription of Warfarin had been discontinued. Both at Inquest and during interview with the Aneurin Bevan University Health Board's Pharmacy Advisors, [redacted] admitted that Warfarin was supplied to Mr. Walters in February to April, 2015 without a valid prescription. [redacted] confirmed at Inquest that he was not aware of the National Patient Safety Agency's Safety Alert No. 18 entitled '*Actions than can make Anticoagulation Therapy Safer*' dated 27.03.07 which states - '*Ensure that before dispensing a repeat prescription for anti-coagulation medication, they check that the patient's INR is being monitored regularly and that it is at a safe level for the repeat prescription to be dispensed*'.
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. The Lawn Medical Practice - (1) failed to use any computer software programmes to support its prescription decisions; (2) breached its contract with the Aneurin Bevan University Health Board in the development and maintenance of an anti-coagulation treatment register; (3) failed to put into place a system of notification to the GP and the Health Care Assistant of a patient's failed attendance for INR testing; and (4) failed to advise the Rhymney Pharmacy Ltd. that Warfarin had been withdrawn due to a lack of INR safety testing.
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 in the area of: ➢ Ensuring pathways of communication are in place in respect of a patient's anticoagulation dosing, INR testing, failed attendance for INR testing and changes of prescription both within the GP Practice and to external agencies including pharmacies providing anti-coagulation prescriptions; and ➢ ensuring the GP Practice is compliant with its responsibilities of maintaining a register of patient anticoagulation dosing and testing.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 28th September, 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; Mr. Mark Drakeford, Minister of Health, National Assembly for Wales; Mrs. Allison Williams, Chief Executive, Cwm Taf University Health Board; [redacted] Primary Clinical Director Aneurin Bevan University Health Board, Division of Primary Care & Networks; [redacted] General Medical Practitioner & Partner, The Lawn Medical Practice, Rhymney; [redacted] Consultant Psychiatrist, North Community Mental Health Team; and [redacted] 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	**9th July 2015** **SIGNED:** [redacted] **Dr. Sarah-Jane Richards** **HM Assistant Coroner**