REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive Officer** **Nhs England** **Po Box 16738** **Redditch** **Worcestershire** **B97 9PT**
1	**CORONER** I am Michael Singleton, Senior Coroner for the Coroner area of Blackburn, Hyndburn & Ribble Valley.
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 16th June 2016 I commenced an investigation into the death of David Wade aged 72 years. The investigation concluded at the end of the Inquest which was heard on 25th day of August 2016. The conclusion of the Inquest was that David Wade died from natural causes contributed to by Warfarin therapy.
4	**CIRCUMSTANCES OF THE DEATH** David Wade who was diagnosed as suffering from atrial fibrillation was placed on Warfarin therapy in December of 2013. Mr Wade was advised that the Warfarin therapy increased his risk of a haemorrhagic stroke. He was not provided with any information as to the symptoms of a bleed on the brain and as to what action he should take in the event of those symptoms occurring. On the 14th June 2016 he complained of severe headaches, vomiting and then collapsed. He was taken by ambulance to the Royal Blackburn Hospital where a CT scan disclosed a large right cerebellar hemispheric haematoma with surrounding oedema which was not survivable.
5	**CORONER'S CONCERNS** During the course of the Inquest the evidence revealed matters giving arise to concern. In my opinion there is a risk that further deaths will occur unless action is taken. In the circumstances it is my duty to report to you the **MATTER OF**

	CONCERN being as follows: - Patients who are provided with anti-coagulant therapy are at an increased risk of the development of haemorrhagic strokes. There appears to be no system in place to provide patients with literature setting out the symptoms of a bleed on the brain and the steps that patients should take in response.
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 1st November 2016. 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 proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following interested person, namely: [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	**06 September 2016** **Signed by:** .... **Michael J H Singleton** **H M Senior Coroner for Blackburn, Hyndburn & Ribble Valley**