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. Mr Steve Moore, Chief Executive, Hywel Dda Local Health Board, Hafen Derwen, Carmarthen, SA31 3BB** **2. Sir David Beehan, Chief Executive, Care & Quality Commission, National Customer Service Centre, Citygate, Gallowgate, Newcastle-Upon-Tyne, NE1 7PA** **3. Ms Gillian Baranski, Chief Executive, Care & Social Services Inspectorate Wales, Welsh Government Offices, Rhydycar Business Park, Merthyr Tydfil, CF48 1UZ**
1	**CORONER** I am Andrew Barkley, Senior Coroner, for the coroner area of South Wales Central.
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 April 2017 I commenced an investigation into the death of Percy Jacks. The investigation concluded at the end of an inquest held at the Welshpool Town Hall on 7th July 2017. The conclusion of the inquest was "Narrative", which was :- "*Percy Jacks died from the effects of a pulmonary embolism in circumstances in which there were failings in the management of his anticoagulation medication*".
4	**CIRCUMSTANCES OF THE DEATH** Percy Jacks passed away in his care home on 15 April 2017. He had been admitted there on 10 February 2017. He had been diagnosed as suffering with a Deep Vein Thrombosis (DVT) and was prescribed "Rivaoxaban" by his General Practitioner on 1st February 2017. Upon confirmation of the DVT, he was prescribed the anticoagulant for three months in accordance with NICE guidelines – until 1st May 2017. Due to a breakdown in communication between the hospital and his GP his course of medication was never renewed and he only took it until 12th March 2017 and did not complete the full course. On the evening of 14 April 2017 he complained of chest pain, was admitted to hospital but released shortly afterwards with a diagnosis of a pulled muscle. There appeared no indication of a DVT / Pulmonary Embolus at that stage. The following morning he was found unresponsive and confirmed deceased. A post-mortem examination confirmed that he had died from a pulmonary embolus.

5	**CORONER'S CONCERNS** During the course of the inquest, and the investigation leading up to it, the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) The investigation revealed that the system for the Bronglais Hospital contacting the GP was poor. The result of the DVT scan which took place on 6 February was sent to the incorrect GP surgery and despite an investigation as to why that happened no satisfactory explanation could be found. (2) The system within the GP surgery for prescribing Rivaroxaban was poor and relied solely on receiving the notification of the results of the scan from the hospital. There was no facility to review the medication to ensure that the correct dosage for the correct period of time continued to be prescribed. (3) The evidence revealed a view from one of the hospital doctors to the effect that DVT management should be undertaken within the hospital setting rather than by the GP's to ensure that a comprehensive and failsafe system operated rather than the somewhat haphazard one revealed by the evidence. (4) The evidence further revealed a practice of sending details of the medication and clinical plan back with the driver of the patient who had taken the patient back from hospital to the care home. (5) Overall the evidence revealed a very fragile system of communication between GP hospital and care home in circumstances in which the deceased had moved between three care homes in a short period of time.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 21st September 2017. 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 the family 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	**27h July 2017** **SIGNED:** **Mr Andrew Barkley** **HM Senior Coroner**