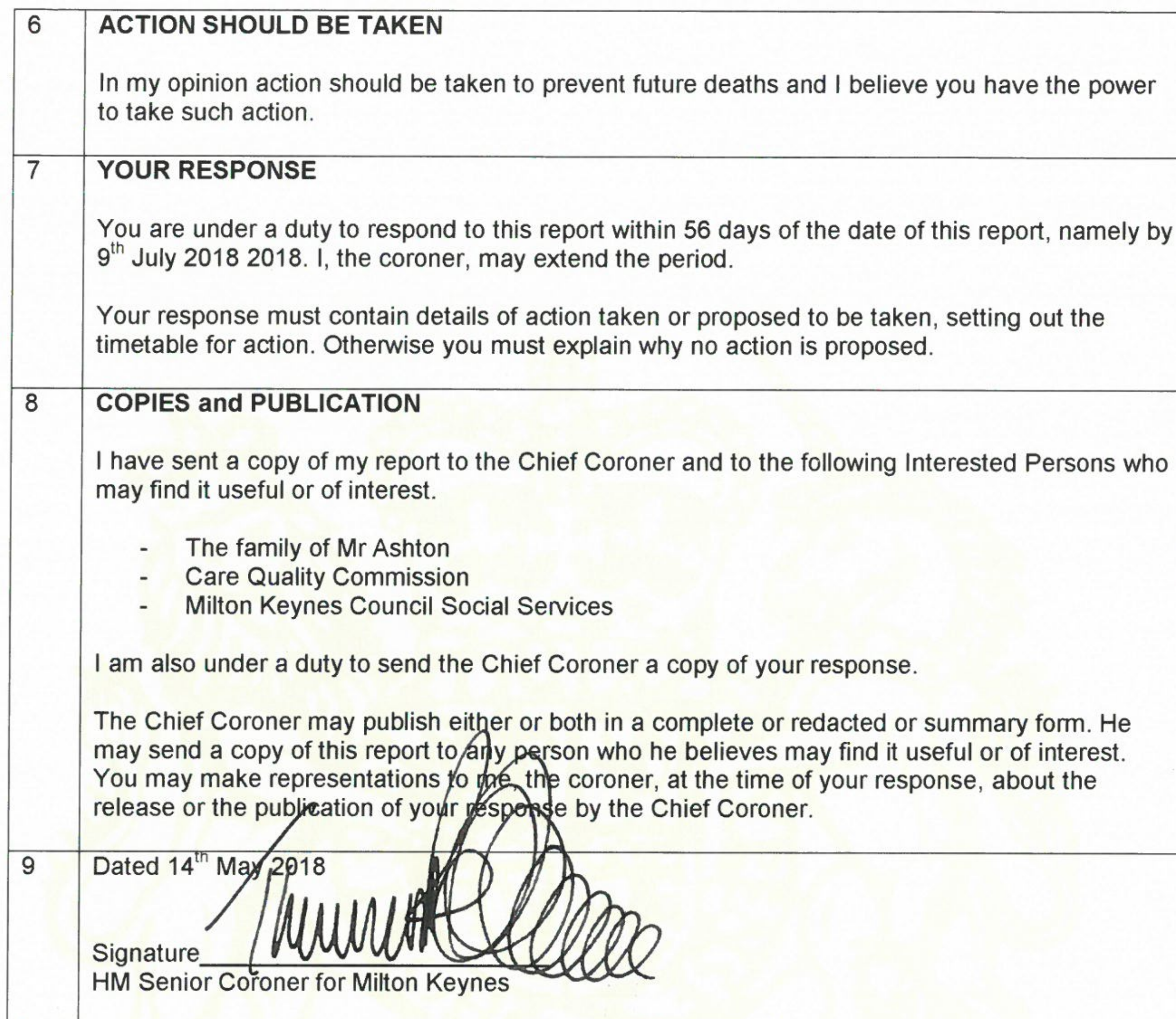
Thomas Ralph Osborne
HM Senior Coroner for Milton Keynes

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Chief Executive, PJ Care**
1	**CORONER** I am Mr Thomas Ralph Osborne, HM Senior Coroner for Milton Keynes
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 20th October 2017 I commenced an investigation into the death of Philip David Ashton, aged 45. The investigation concluded at the end of the inquest on 23rd April 2018. The narrative conclusion of the inquest was: *The deceased was administered warfarin in error on 13th, 14th, and 15th October 2017. On the morning of the 17th October 2017 he was found on the floor of his room at Mallard House, Milton Keynes, bleeding from his arteriovenous graft in his left thigh. There was no attempt to stop the bleeding until the paramedics arrived on the scene and applied a tourniquet. The delay resulted in a missed opportunity to prevent the hypovolaemic shock and the medication error contributed to the serious degree of bleeding. He was stabilised and transferred to Milton Keynes Hospital where he died at 12.37 pm.*
4	**CIRCUMSTANCES OF THE DEATH** The deceased was a resident of Mallard House Milton Keynes. He attended the hospital three times a week for dialysis. He had an arteriovenous graft on his left thigh. On the 13th, 14th, and 15th October 2017 the deceased was administered warfarin in error. He was found in his room on the 17th October 2017 bleeding from his graft. The ambulance attended and were surprised that no attempt had been made by the staff to resuscitate or stop the bleeding.
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) That warfarin was administered to the deceased in error and the home should review their medication procedures and put in place a robust system for the administration of anti coagulation medication (2) The staff were not able to deal with an emergency situation. (3) The ambulance staff were not given any information about the deceased as to his medical history or medication. The notes relating to the deceased should have been available to them.

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 9th July 2018 2018. 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 who may find it useful or of interest. - The family of Mr Ashton - Care Quality Commission - Milton Keynes Council Social Services 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 14th May 2018 Signature  HM Senior Coroner for Milton Keynes