REGULATION 28: REPORT TO PREVENT FUTURE DEATHS.

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • NORTH WEST AMBULANCE SERVICE Copied for interest to: • Next of kin • Chief Coroner • Each Step Nursing Home
1	**CORONER** **I am Rachel Galloway, Assistant Coroner, for the Coroner area of Manchester (City).**
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	**INQUEST** I concluded the inquest into the death of Marie Hilda Millward Winter on 26th September 2017 and recorded that he/she died from: 1a Intracranial haemorrhage 1b Traumatic Injury ii. Dementia Atrial Fibrillation (on Apixaban), Hypertension.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Millward Winter suffered a fall in her bedroom at the Each Step Nursing home on the morning of the 19th August 2017. It is likely that Mrs Millward Winter fell from a standing position after getting out of bed. She sustained a head injury, which was likely caused by her coming into contact with the bedside table during the fall. The head trauma led to a bleed on the brain. This bleed was increased due to Apixaban medication (which was given to Mrs Millward Winter following the fall at Each Step Nursing Home on the 19th August 2017). She was taken by ambulance to North Manchester General Hospital. The bleed was highlighted following CT scan and palliative care was provided. Mrs Millward Winter passed away at North Manchester General Hospital on the 2nd September 2017. During the course of the inquest, I heard evidence that the care staff administered Mrs Millward Winter's standard morning medication at around 9 am on the 19th

	August 2017. This medication included her regular dose of Apixaban (anticoagulant medication) 5 mg, which was prescribed to be given twice daily. I heard evidence that this medication was given to Mrs Millward Winter after the fall and after the ambulance technicians in attendance advised that her morning medication was to be given (prior to relaying her to hospital). On hearing the evidence of the treating clinicians at Withington hospital, I concluded that the administration of her normal dose (5 mg) of Apixaban medication, following her fall on the 19th August 2017, contributed to Mrs Millward Winter's death. In particular, whilst the head injury itself had caused the bleed to occur, the evidence from the treating clinician at Wythenshawe Hospital was that the Apixaban increased the severity of that bleed and contributed to her death. The clinician advised that the anticoagulant should not to have been given to Mrs Millward Winter at Each Step Nursing home following Mrs Millward Winter's fall on the morning of the 19th August 2017.
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 evidence was that the medication (Apixaban) was given to Mrs Millward Winter at Each Step Nursing Home on the advice of and/or in the presence of the Ambulance Technicians from North West Ambulance Service after she had sustained a head injury and prior to transporting her to hospital. The concern is that the administration of this anticoagulation medication on the morning of the 19th August 2017, following a head injury, worsened an internal bleed and contributed to Mrs Millward Winter's death. It is of concern that such medication has been given when the patient has suffered a head injury (and is at risk of an internal bleed). It is of concern that the medication has been given on the advice of and/or in the presence of the ambulance technicians.
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 **12th March 2019**. 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 Interested Persons. I have also sent it to organisations 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	**Signed:**  **Rachel Galloway** **15th January 2019** **HM Assistant Coroner for** **Manchester City Area**