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:** **Chief Executive, Welsh Ambulance Service Trust**
1	**CORONER** I am Rachel Knight, Assistant 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 28th February 2018 an inquest was opened into the death of Marion Hilda Prance. The investigation concluded on the 13th May 2019. The conclusion of the inquest was narrative and read as follows: On 24th February 2018 Mrs Prance had an unwitnessed fall at Garth Olwg Care Home. In 2016 she had survived a stroke, and was thereafter prescribed Rivaroxaban as an anti-coagulant drug. During the fall, Mrs Prance suffered a head injury and was then given her morning dose of Rivaroxaban on the advice of paramedics. She was subsequently diagnosed as having a subdural haematoma at hospital, and during the day her condition suddenly deteriorated. It became clear that she had suffered a catastrophic brain bleed, which was unsurvivable. The administration of the Rivaroxaban may have contributed to the extent of the brain bleed.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Prance had significant co-morbidities and was prescribed many daily medications. She self-managed her type 2 diabetes. She was living in Garth Olwg Care Home, but was of full capacity and living semi-independently. She accidentally fell over when getting off the commode in her bedroom, and banged her head as well as sustaining a clavicle fracture. Care home staff rang for an ambulance which attended promptly at around 7am. Paramedics were concerned that since there may be delays at the Royal Glamorgan Hospital, it would be sensible for Mrs Prance to eat breakfast before they took her in.

	Staff at the Care Home asked the paramedics whether they should administer the usual morning medications. Paramedics had sight of the Medication Administration Record for Mrs Prance which included Rivaroxaban, a fast-acting anti-coagulant drug. Notwithstanding the fact that Mrs Prance, aged 82 had fallen and banged her head, paramedics advised the nursing staff to administer all her usual medications, so as to maintain the status quo, since 'missing medications may cause additional problems to the presenting complaint'. Paramedics had an awareness of the dangers of warfarin, and accepted in evidence that in a similar scenario with warfarin, they would have 'held off' administering warfarin. They were unconcerned about Rivaroxaban. In evidence, the paramedic said that he had not received any training about the dangers of Rivaroxaban. A subdural haematoma was subsequently diagnosed, and Mrs Prance had developed a catastrophic brain bleed by 6pm the same day. She died the next day. It may be that the Rivaroxaban administered at around 7:30am contributed to the extent of Mrs Prance's brain bleed.
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) A paramedic with 40 years of experience was unaware of the dangers of administering Rivaroxaban, a blood-thinning medication to an elderly lady who had suffered a fall and banged her head; (2) The training of paramedics in relation to the dangers of bleeds in patients who have fallen and are prescribed Rivaroxaban and other similar new style anti-coagulant drugs; (3) The awareness of fast-acting anti-coagulant drugs and the implications of administering them; and (4) The awareness by paramedics that in patients with head injuries following a fall, the true extent of the head injury will not be immediately obvious, and extra caution is required.
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 10th July 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 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	**15th May 2019** **SIGNED:** **Rachel Knight** **Assistant Coroner**