REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] GP Principal, Brace Street Health centre, Walsall, WS1 3PS** **2. Care Quality Commission**
1	**CORONER** I am Zafar Siddique, Senior Coroner, for the coroner area of the Black Country.
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 15 April 2019, I commenced an investigation into the death of Mrs Annie Lloyd. The investigation concluded at the end of the inquest on 19 September 2019. The conclusion of the inquest was a short narrative conclusion of: **Mrs Lloyd was on anti-coagulation medication of warfarin. She was initially on a level of 2.5mg. This was increased by the General Practitioner on the 4 March 2019 to 3mg. She continued to take an additional dosage of 2mg giving a total of 5mg for around 15 days. On the 6 April 2019 she was found unresponsive and admitted to hospital after developing a subdural haematoma. It is not clear on the evidence if the increased dosage of warfarin gave rise to the bleed or that it was a spontaneous bleed or alternatively involved a minor traumatic event.** The cause of death was: 1a Raised Intracranial Pressure b Sub Dural Haematoma
4	**CIRCUMSTANCES OF THE DEATH** i) Mrs Lloyd was on warfarin medication and had a medical history including atrial fibrillation. ii) She would attend the anti-coagulation clinic at Hospital and her last attendance at the clinic on the 7 March 2019 confirmed she was on 2.5mg per day. She would normally take two brown tablets (1mg) and one white tablet (0.5mg) giving a total of 2.5mg. iii) On the 4 March 2019, a prescription for 3mg warfarin was issued by her GP, [redacted] The GP has suggested that they were informed by family members that she now required a dosage of 3mg. iv) From the evidence it appears that she was then taking one blue tablet (3mg) and two brown tablets giving a dosage of 5 mg over a period of around two

	weeks. v) Mrs Lloyd started to experience chest pain and they went back to the surgery to see the GP on the 1 April 2019. The family told the GP that she had taken 5mg and the GP understood this to mean she had taken a single "one-off" dosage and reduced the dosage to 2mg for a week and then for her to recommence at 2.5mg vi) Evidence from a Consultant Haematologist confirmed warfarin is used as anticoagulation to prevent strokes and treat atrial fibrillation. The increased warfarin may have caused a bleed or expansion of a bleed caused by another event and we cannot rule out a mild trauma event; although there was no clear evidence of a traumatic injury. vii) On the 6 April 2019, Mrs Lloyd was found at her home unconscious. On arrival at New Cross Hospital she was deeply comatose. A CT Scan of her head revealed a large subdural haematoma with raised intracranial pressure. Sadly, her condition declined rapidly, and she passed away the same day.
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. Evidence emerged during the inquest that there was an inadequate process in place for checking the patient's warfarin level dosage. It appears that a "yellow book" confirming the dosage was being copied and the GP issued the prescription without checking this. 2. The GP practice claim to have placed reliance on the family to confirm the dosage required.
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. 1. The GP Practice may wish may wish to review its processes in place in general when dealing with prescriptions including repeat prescriptions. More specifically, they may wish to review the process in place when changing a dosage of warfarin. 2. The CQC may wish to further review the GP Practice and consider whether further inspections are necessary.

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 26 December 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 the following Interested Persons; Family. 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	**30 October 2019** **Mr Zafar Siddique** **Senior Coroner** **Black Country Area**