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.** His Honour Judge Peter Thornton QC, HM Chief Coroner. **2.** [redacted], Minister for Health, National Assembly for Wales. **3.** Mrs. Allison Williams, Chief Executive, Cwm Taf University Health Board. **4.** Ms. Judith Paget, Chief Executive, Aneurin Bevin University Health Board. **5.** [redacted] Legal Services Manager, Aneurin Bevin University Health Board. **6.** Care & Social Services Inspectorate, Welsh Government Office, Rhydycar Business Park, Merthyr Tydfil, CF48 1UZ. **7.** [redacted] Bryntirion Surgery, West Street, Bargoed, CF81 8SA. **8.** Directors of Brindaven Care Home Limited Commercial Street, Aberbargoed, Caerphilly, CF81 9BU.
1	**CORONER** I am Dr. Sarah-Jane Richards, Assistant Coroner, for the coroner area of Powys, Bridgend and Glamorgan Valleys
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 22nd May 2015, I commenced an investigation into the death of Mrs. Mary Patricia James, 80 years old. The investigation concluded at the end of the inquest on the 21st August, 2015. The conclusion of the inquest was '*Ischaemic leg contributed to by inadequate Warfarin monitoring and dosing'.*
4	**CIRCUMSTANCES OF THE DEATH** Mrs. Mary James had previously received a prosthetic heart valve for which anti-coagulation therapy was required. Monitoring and dosing her anticoagulation therapy was undertaken by the Royal Gwent Hospital (RGH) with the Care Home providing blood samples for analyses. Between the period 16th October 2014 and May 2015 only one blood sample was sent for analysis by the Care Home of its resident Mrs. James which was dated 11.03.15. This sample was incorrectly labelled by staff at the Home therefore the analysis could not be undertaken. From the evidence heard at Inquest there was a failure to discuss the difficulty of obtaining blood samples from Mrs. James with her family, [redacted] (GP) and the INR Unit at RGH. There was no training provided to the member of staff responsible for failing to comply with requirements for the labelling of blood samples for INR testing. Letters were sent from the INR Unit to the Care Home dated 27.10.14; 25.11.14; an undated 3rd letter advising of the failure to send blood samples for INR monitoring and 08.05.15 confirming discontinuation of INR monitoring. The letters dated 25.11.14 and the undated letter were copied to the GP Surgery with a further letter sent to the GP dated 07.04.15. However, neither party responded to these letters. This did not raise any concern or prompt any action by Dr. Turner although she confirmed that such a

	letter had arrived in her 'drop box'. However, she had noted the INR Unit's letter advising of the lack of INR monitoring had been sent originally to Mrs. James' previous GP's practice. Dr. Turner did not correct this error or ensure a member of her Practice informed the INR Unit of Mrs. James' transfer to the Bryntiron Street Surgery thereby permitting the error to be perpetuated. The GP further stated that only one letter had arrived in her drop box so she assumed any other correspondence must have gone to the drop box of her colleagues who it appeared had similarly failed to respond. The Care Home Manager at Inquest confirmed that Mrs. Mary Patricia James was most likely receiving her Warfarin tablets as they were being reordered at appropriate time intervals however, he could not be certain from the records maintained. However, at times she refused her medication and it was not clear whether or not that included Warfarin.
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) Inadequate monitoring of INR levels in a patient suffering from dementia; (2) Lack of certainty whether Warfarin was being taken by the patient; (3) Inadequate communication between the INR Unit, the Care Home and the GP regarding this patient's anticoagulation monitoring and the potential need for therapy adjustment; and (4) That against this background and the Care Home's concern about a possible ischaemic leg, Mrs. James was not admitted to hospital on the 15th May, 2015 when there may have been a window of opportunity to have adjusted the anticoagulation therapy.
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 in the area of: ➢ Ensuring communications from the INR Unit are responded to by institutions responsible for the care of an individual requiring anticoagulation therapy. ➢ Ensuring communications from the INR Unit to the GP are responded to including new patient transfers. ➢ Ensuring training is provided by the Care Home to those with responsibility for labelling of bloods for INR monitoring. ➢ Compliance with keeping reliable medical records for prescription and ingestion of anticoagulation therapy and incidence of medication non compliance . ➢ In the event a patient declines anticoagulation medication or blood sampling, to ensure such non-compliance is reported to the GP and the INR Unit for appropriate management. ➢ Ensuring a process is put into place within the Bryntirion Surgery to recognise and act on a patient's failure to undergo INR monitoring when the Surgery is issuing repeat prescriptions of anticoagulation therapy.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 4th November, 2015. 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 His Honour Judge Peter Thornton QC, HM Chief Coroner; Mr. Mark Drakeford, Minister for Health, National Assembly for Wales; Mrs. Allison Williams, Chief Executive, Cwm Taf University Health Board; Ms. Judith Paget, Chief Executive, Aneurin Bevin University Health Board; Mr [redacted], Legal Services Manager, Aneurin Bevin University Health Board; Care & Social Services Inspectorate, Welsh Government Office, Rhydycar Business Park, Merthyr Tydfil, CF48 1UZ; [redacted], Bryntirion Surgery, West Street, Bargoed, CF81 8SA; andthe Directors of Brindaven Care Home Ltd, Commercial Street, Aberbargoed, Caerphilly, CF81 9BU. 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: 4th September 2015** **SIGNED:**  **Dr. Sarah-Jane Richards** **HM Assistant Coroner** **Powys, Bridgend & Glamorgan Valleys**