**ANNEX A**

## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1. His Honour Judge Peter Thornton QC, Chief Coroner of England and Wales.**<br>**2. Mr. Mark Drakeford, Minister for Health, National Assembly for Wales.**<br>**3. Mrs. Allison Williams, Chief Executive, Cwm Taf University Health Board**<br>**4. Practice Manager, Practice 1, Keir Hardie Health Park, Aberdare Road, Merthyr Tydfil. CF48 1BZ**<br>**5.** [redacted] |
| 1 | **CORONER**<br><br>I am Mr Graeme Hughes, Assistant Coroner, for the coroner area of Powys, Bridgend and Glamorgan Valleys |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On the 3rd October 2014, I commenced an investigation into the death of Mr Ronald Francis Bonfield. The investigation concluded at the end of the inquest on the 9th September 2015. The conclusion of the inquest was - 'The deceased took Warfarin as an anti-coagulant. On the 29th September 2014 he sustained a head injury whilst at home when a chair he sat on toppled backwards. He was diagnosed with a subdural haematoma. He had sustained this injury at a time when he was over anti-coagulated. His INR levels were not being monitored as required. His untreatable condition deteriorated and he passed away at Prince Charles Hospital on the 2nd October 2014 at 10pm'. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Whilst at home on 29th September 2014, the deceased sustained a head injury when he struck his head on the handle of a kitchen door. On 1st October 2014 he was admitted to Prince Charles Hospital. A head injury was diagnosed, but he was not for active surgical intervention. He deteriorated and died at Prince Charles Hospital on 2nd October 2014. |

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| 5 | **CORONER'S CONCERNS**<br><br>The matters of concern as follows:-<br><br>(1) The practices and procedures implemented by the Practice 1, Keir Hardie Health Park, GP Surgery following Mr Bonfield's death (with regard to monitoring the compliance of the Health Boards District Nurse Teams following delegation to undertake a patient's INR testing) is not uniform and/or implemented across all of the Health Boards Level 4 Accredited GP practices.<br>(2) The practices and procedures implemented by Practice 1, Keir Hardie Health Park Surgery act as a *check and balance* to reduce the risk of an unmonitored/*unactioned* failure on the part of the District Nurse service to undertake the task(testing the patients INR level) delegated to them by the GP practice concerned.<br>(3) Until such action is taken there remains a risk that a future death(s) could occur in similar circumstances to Mr Bonfield's, where delegated INR testing has not been done leading to un-monitored over anti-coagulation |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>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:<br><br>➢ Ensuring that all level 4 accredited GP practices across the Cwm Taf Health Board area follow the (monitoring) practices & procedures implemented by the Practice 1, Keir Hardie Health Park, GP Surgery following Mr Bonfield's death |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 6th November, 2015. I, the Coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner; Mr. Mark Drakeford, Minister of Health, National Assembly for Wales; Mrs. Allison Williams, Chief Executive, Cwm Taf University Health Board; Practice Manager, Practice 1, Keir Hardie Health Park, Aberdare Road, Merthyr Tydfil. CF48 1BZ [redacted]<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **11th September 2015** **SIGNED:**<br><br>**Mr Graeme Hughes**<br>**HM Assistant Coroner** |