Thomas Ralph Osborne
Senior Coroner for Milton Keynes

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Sir Andrew Dillion, Chief Executive NICE**
1	**CORONER** I am Thomas Ralph Osborne, Senior Coroner for Milton Keynes
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 15/01/2015 I commenced an investigation into the death of Frederick Squires, 87. The investigation concluded at the end of the inquest on 13/10/2016. The conclusion of the inquest was a Narrative conclusion as attached.
4	**CIRCUMSTANCES OF THE DEATH** On 4th December 2014 Mr Squires was involved in a road traffic collision where he was struck by the rear of a slowly reversing vehicle. The collision was low impact but on falling to the floor, Mr Squires struck his head. He was taken to Milton Keynes Hospital where a CT was performed and his warfarin and medications were stopped. He was admitted to ward 19 on 5th December 2014 and was discharged home on 6th December 2014 with instructions to see his GP as an outpatient to arrange another CT scan and he was not to start taking his medications until the results of the second CT scan were available. His second CT scan was booked for 29th December 2014. Early on the morning of the 21st December 2014 the deceased was found on the toilet in the bathroom. An ambulance was called and the deceased was taken to the Luton and Dunstable hospital where a CT scan of his head showed he had an acute ischaemic stroke. He died on the 30th December 2014. [redacted] has maintained that she was concerned at the withdrawal of all his medications and had expressed this on several occasions.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In that there was no clear indication as to whether the warfarin should only be started after a further CT scan or after the period of 14 days regardless of a scan. In my opinion there is a risk that future deaths will occur unless action is taken to give clear guidance. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – (1) That there is no guidance available to clinicians as to when Warfarin should be recommenced for a patient who has suffered a head injury. If clear guidance is not available it will lead to confusion amongst clinicians and the patient with the result that it is commenced too soon and the patient develops a bleed or too late and the patient suffers a stroke.

HM Coroners Office, Civic Offices, 1 Saxon Gate East, Central Milton Keynes, MK9 3EJ
Tel 01908 254326 | Fax 01908 253636

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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 26th December 2016. 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 - The family of Mr Squires I have also sent it to CQC 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	Dated 31st October 2016 Signature_____ Senior Coroner for Milton Keynes

HM Coroners Office, Civic Offices, 1 Saxon Gate East, Central Milton Keynes, MK9 3EJ
Tel 01908 254326 | Fax 01908 253636