REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Secretary of State for Health.**
1	**CORONER** I am John Pollard, senior coroner, for the coroner area of South Manchester
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 13th November 2013 I commenced an investigation into the death of Stephen Ellis dob 23rd December 1953. The investigation concluded on the 4th March 2014 and the conclusion was Misadventure. The medical cause of death was 1a Haemopericardium 1b Recent aortic root graft and aortic valve replacement surgery and subsequent warfarinisation 1c Aortic stenosis and aortic root aneurysm 2 Ischaemic and hypertensive heart disease, long term haemo-dialysis due to previous nephrectomies for renal cell carcinoma.**
4	**CIRCUMSTANCES OF THE DEATH: The deceased was admitted to hospital for the necessary heart surgery and he was acknowledged to be a patient with significant co-morbidities. After the surgery he was administered warfarin and thereafter there appears to have been some blood oozing from around the grafted area. When he was administered the warfarin whilst in hospital his INR levels were carefully monitored but upon his release from hospital these checks were reduced to 'weekly' and it is apparent that his INR was rising without this being properly noted at the time. The consultant surgeon who performed the operation told me in evidence that warfarin home monitoring kits are readily available and widely used outside the UK. If Mr Ellis had had such a monitoring kit, he may have registered a higher than acceptable INR and this may have been picked up. If so, it was the view of the surgeon, the outcome might have been different and he could have survived.**
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. **– I believe it would be good practice to supply warfarin home management kits to 'high risk' patients who have undergone heart surgery and are subsequently warfarinised. The cost of such kits would probably equate to, or be less than, the cost of hospital monitoring.**
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. It is essential that full information is passed promptly to the GP practice of a patient being discharged.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **1st May 2014**. 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 namely [redacted] **(widow of the deceased),** [redacted] **(surgeon), the Coroners Society of England and Wales**. I have also sent it to **the Chief Executive Central Manchester Foundation NHS Trust** 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	**14th January 2014** **John Pollard, HM Senior Coroner**