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. Chief Executive - Cwm Taf Health Board** **2. [redacted] – wife of deceased** **3. [redacted] – parents of deceased** **4. Chief Coroner**
1	**CORONER** I am Andrew Barkley, Senior 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 28th May 2014 I commenced an investigation into the death of Nicholas James Megginson, aged 45 years. The investigation concluded at the end of an inquest on the 6th August 2014. The conclusion of the inquest was that of a narrative conclusion; *"Nicholas James Megginson died from effects of a pulmonary thromboembolism arising from him fracturing his ankle when he fell on the 5th May 2014. He was considered high risk for developing a thromboembolism by virtue of the fracture and his underlying vascular impairment. Whilst he was prescribed prophylaxis for venous thromboembolism which was administered after his surgery on the 6th May, he was not prescribed anything thereafter"* The medical cause of his death was recorded as:- 1a. Pulmonary Thromboembolism 1b. Deep Venous Thrombosis 1c. Fractured Left Ankle (operated 06/05/2014)
4	**CIRCUMSTANCES OF THE DEATH** The deceased was found unresponsive by his wife at the home address on the 22nd May 2014. He had previously fractured his left ankle on the 5th May 2014 and had an operation on 6th May before being discharged home on 7th May. A post mortem examination found that he had died from the effects of a pulmonary embolism.
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. The evidence revealed that there was no consistent advice given to patients discharged post-surgery regarding the risks of venous thromboembolism either orally or in writing incorporating advice in relation to concerning clinical signs which may arise to indicate urgent medical treatment is required.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 5th November 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 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	**11th September 2014** **SIGNED:**