REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Dr Andrew Goodall, Chief Executive, NHS Wales**
1	**CORONER** I am Christopher John Woolley, Assistant Coroner, for the Coroner area of Cardiff and the Vale of Glamorgan
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 12th November 2014 I commenced an investigation into the death of Phyllis Eleanor Barlow aged 83. The investigation concluded at the end of the inquest on 29th January 2015. The medical cause of death was: 1A Subdural haemorrhage (operated) and 2. Fracture left neck of femur (operated), Deep vein thrombosis (fully anti-coagulated), and the conclusion of the inquest was a narrative conclusion as follows: "Phyllis Eleanor Barlow died on the 8th November 2014 from a subdural haemorrhage sustained after a fall at home on the 30th September 2014. It is likely that the fall and her death were contributed to by significant natural disease and the appropriate medication given for it."
4	**CIRCUMSTANCES OF THE DEATH** Phyllis Barlow was on a variety of medication for her existing co-morbidities, including warfarin to treat a deep vein thrombosis. On 29th September 2014 she fell in the GP surgery car park striking her head. She was treated for a minor abrasion and her observations were all normal. She went home after this without any difficulty. On 30th September 2014 she fell and struck her head at home, causing a subdural haemorrhage and fracturing her hip. She was taken to hospital where she was treated appropriately but died on 8th November 2014.
5	**<u>CORONER'S CONCERN</u>** During the course of the inquest the evidence revealed a matter 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 **MATTER OF CONCERN** is as follows. – (1) At the time of her fall in the GP car park on 29th September 2014 NICE guidelines (on head injuries) were in place to the effect that anyone suffering a head injury who was on warfarin should be admitted to hospital forthwith and undergo a CT scan. [redacted] who appeared at the inquest on behalf of the GP practice testified that these NICE guidelines were not known or appreciated by her GP practice at the time even though they were in force. Mrs Barlow was not admitted to hospital as she should have been on 29th September 2014. [redacted] subsequent enquiries have revealed that

	there is widespread ignorance of these NICE guidelines among GP colleagues, although they are appreciated by the ambulance service, and A&E departments. The Coroner is concerned that steps should be taken to make GP surgeries in Wales aware of the importance of these NICE guidelines, and that anyone who suffers a head injury while being treated with Warfarin should be admitted to hospital forthwith and a CT scan undertaken on them..
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 March 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 the Chief Coroner and to the following Interested Persons 1. [redacted] 2. [redacted] I have also sent it to [redacted], Deputy CMO Welsh Government. 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	**29th January 2015** **C J Woolley, Assistant Coroner**