Roger Linton Hatch
Senior Coroner for North West Kent

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Dartford & Gravesham NHS Trust, Ministry of Health**
1	**CORONER** I am Roger Linton Hatch, Senior Coroner for North West Kent
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 28/01/2014 I commenced an investigation into the death of Koshalaya Rani Sawhney, 85 . The investigation concluded at the end of the inquest on 16 March 2015. The conclusion of the inquest was I conclude that the death of Koshalaya Rani Sawhney was entirely due to the failure of the Trust to properly carry out INR tests and in prescribing anticoagulant medication without the result of the tests being available which caused her to suffer a subdural haemorrhage which led to her death. Mrs Sawhney was admitted to DVH on 7th January 2014 with a hip complaint/unable to walk.
4	**CIRCUMSTANCES OF THE DEATH** Subdural haemorrhage causing increase in the intracranial pressure and subsequent multiple infarcts and ischaemia. Raised blood warfarin
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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) Failure to properly carry out INR tests appropriately or at all (2) Continuing to administer anticoagulant medication without having carried out INR tests (3)

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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 27 May 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 [redacted] 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 31 March 2015 Signature_____ Senior Coroner for North West Kent

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