**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**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>1. **Chief Coroner**<br>2. **Minister for Health, National Assembly for Wales**<br>3. **Chief Executive, Cwm Taf University Health Board**<br>4. |
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| 1 | **CORONER**<br><br>I am Dr. Sarah-Jane Richards, Assistant Coroner, for the coroner area of Powys, Bridgend and Glamorgan Valleys |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On the 16th January, 2015 I commenced an investigation into the death of Mrs. Hilda May Harris. The investigation concluded at the end of the inquest on the 17th April, 2015. The conclusion of the inquest was '*natural causes exacerbated by prescribed medication*'. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Mrs. Harris (86 years) suffered a previous myocardial infarction and cerebral vascular accident. She also suffered from gout. In or around October 2014 her Consultant Cardiologist, prescribed Warfarin and in consequence, Mrs. Harris' INR levels were monitored by the Community District Nurse team albeit, dose adjustments were the responsibility of the Royal Glamorgan Hospital.<br><br>In December 2014, Colchicine and Allopurinal medications were prescribed to treat a flare up of Mrs. Harris' gout. As either drug could affect the metabolism of Warfarin, an additional INR check was requested by the hospital for the 30.12.14. Although the request was received by the District Nurses' office, it was not transferred from one sheet of papers to another. In consequence, the INR test was not undertaken.<br><br>Mrs. Harris' daughter, had been warned by the pharmacist of the importance of INR monitoring when combining Allopurinal with Warfarin. Thus, when the District Nurse failed to undertake the INR test as arranged by the hospital, contacted the GP surgery to advise of the omission. This message, although noted by the surgery, was not received or not acted upon by the Community District Nurses.<br><br>On the 04.01.15, Mrs. Harris suffered a cerebral infarction with an intra-cerebral haemorrhage. Pathologist, attributed the extensive bleed to elevated levels of Warfarin. |

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| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>(1) The current booking system for community INR testing is unreliable with scope for appointments not being transferred from one set of papers to another.<br><br>(2) Where an omission occurs, the notification system (by the family or carers) also appears unreliable. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>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 in the area of:<br><br>➢ Ensuring a dependable system of booking INR testing with the Community District Nurse team is established; and<br><br>➢ Ensuring a dependable system for communication between patients and their community District Nurses. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 22nd June, 2015. I, the Coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner; Mr. Mark Drakeford, Minister of Health, National Assembly for Wales; Mrs. Allison Williams, Chief Executive, Cwm Taf University Health Board; [redacted] Consultant Cardiologist, Cardiology Department, Royal Glamorgan Hospital; and to the family representative, [redacted]<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **24th April 2015** **SIGNED:** [redacted]<br><br>**Dr. Sarah-Jane Richards**<br>**HM Assistant Coroner** |