REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive of West Wales General Hospital Glangwili Carmarthen**
1	**CORONER** I am Jonathan Mark Layton senior coroner, for the coroner area of Carmarthenshire and Pembrokeshire.
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 3rd September 2013 I commenced an investigation into the death of Margaret Hions . The investigation concluded at the end of the inquest on 12th February 2016. The conclusion of the inquest was a narrative conclusion namely that: Margaret Hions died on 27th August 2013 from pulmonary infarction and coronary artery atherosclerosis in an elderly woman who had sustained breakdown of a left gluteal haematoma caused by tinzaparin therapy. There were shortcomings in the management of her care at Glangwili Hospital.
4	**CIRCUMSTANCES OF THE DEATH** (1) Mrs Hions was admitted to Glangwili Hospital on 1 July 2013 with increasing shortness of breath, decreased mobility, loss of appetite, nausea and vomiting. At the time of her admission she was prescribed warfarin. A decision was made to replace warfarin with tinzaparin. (2) Mrs Hions remained in hospital and during her admission a large bruise was observed which expanded rapidly. (3) As a result of this the tinzaparin was stopped. (4) Mrs Hions was subsequently transferred to the Prince Philip Hospital where she passed away on 27th August 2013.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed this 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 **MATTERS OF CONCERN** is as follows: (1) That there should be a review of the current Health Board practice in the prescribing of tinzaparin medication and the monitoring of blood levels. (2) That the importance of monitoring creatinine clearance as per Health Board clinical pharmacy policy to be reiterated to medical team and pharmacists. These matters were identified by a Root Cause Analysis Investigation report but it was unclear at the inquest whether these recommendations have yet been acted upon.

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 the 8th April 2016. 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 Person: [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	**12 February 2016** **Signed:**