*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Community Nurse Locality Team Lead**
1	**CORONER** I am Andrew Cox, the Senior Coroner for the coroner area of Cornwall and the Isles of Scilly.
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 20/10/2023, I concluded an inquest into the death of Valerie Ann Simmons who died on 11/01/2023. . The medical cause of death was recorded as: 1a) Hypovolaemic Shock 1b) Left Thigh Haematoma 1c Low Molecular Weight Heparin and Warfarin Therapy with high INR for Metallic Mitral Valve Replacement. II Ischaemic Heart Disease, Congestive Cardiac Failure, Frailty I recorded a Narrative Conclusion that Mrs Simmons died from a known complication (bleeding) of a necessary medical procedure (anti-coagulation.)
4	**CIRCUMSTANCES OF THE DEATH** Mrs Simmons was well known to the community nursing team. She had a past medical history that included a mitral valve replacement in 2007 following which she was prescribed warfarin with a target therapeutic INR of 3.5. In December 2022, it was noted her INR levels were sub-therapeutic and so she was prescribed bridging Fragmin therapy. Her NEWS score was recorded as 5. Community nurses attended daily. On 7/1/23, she had an injection of Fragmin into her left thigh. On 8/1/23, she was found to have developed a large haematoma. In spite of her changed presentation, there were no recorded observations that objectively demonstrated she was otherwise 'well.' Her INR was tested on 9/1/23 and found to be 4.9. A doctor attended and advised admission into hospital which Mrs Simmons initially declined.

	She subsequently changed her mind but an email to advise the doctor did not reach him. An ambulance was later called, and Mrs Simmons was admitted into Royal Cornwall Hospital. She deteriorated and died in the hospital on 11/1/23.
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. – It was accepted in evidence that: - Where there was a change in a patient's presentation, it would be expected that a set of observations would be undertaken and recorded in a patient's notes; - Further training related to the risks of hypovolaemia in an anti-coagulated patient would be beneficial.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR 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 16/12/2023. 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	**[DATE]** **[SIGNED BY CORONER]** **20/10/2023**