REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

1.	**CORONER** I am Sonia Hayes, Area Coroner, for the coroner area of Essex.
2.	**DATE OF REPORT** **28 MAY 2026**
3.	**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.	**THIS REPORT IS BEING SENT TO** 1. Chief Executive of Mid & South Essex NHS Foundation Trust 2. NHS England 3. Integrated Care Board – Mid & South Essex You are under a duty to respond to this report within 56 days of the date of this report, namely by 23 JULY 2026. I, the coroner, may extend the period if an appropriate application is made.
4.	**YOUR RESPONSE** 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
5.	**SUMMARY OF CORONER'S CONCERN** **1. Lacey Heath was a clinically complex patient who following her Prosthetic Aortic Valve Replacement with Aortic graft requiring lifelong anticoagulation to mitigate known risks associated with thrombosis.** **2. Clinicians struggled to achieved therapeutic anticoagulation for Lacey ad combinations of therapy were tried. Acenocoumarin as an alternative led to very high INR readings. The GP referred Ms Heath back to the hospital due to the complexity of the case.**

	3. **Ms Heath's experienced clinical team recommended an at home monitor be utilised to attempt to achieve a therapeutic range given the complexity of her dosing requirements, so daily readings could be taken. The NICE Guidance Anticoagulation -Oral last updated August 2025 states that at-home monitor is not funded by the NHS, and Ms Heath was on a low income and was prohibited from using this tool to attempt to achieve a therapeutic range with appropriate oral medications.** 4. **Ms Heath was at increased risk of developing complications with her INR results, and this was not escalated and her clinic appointment with INR testing remained the same.** 5. **Hospital Medical records were not compliant with the requirements of healthcare regulators and led to a lack of appreciation of Ms Heath's concerns, the complexity of her case and the ongoing risk to Ms Heath. Staff use an electronic platform to record INR and medication dose and have no other place to record anticoagulation records within the anticoagulation clinic.**
6.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths, and I believe each of you have the power to take such action.
7.	**INVESTIGATION AND INQUEST** On 21 February 2025, I commenced an investigation into the death of Lacey Carole Anne HEATH, aged 34 years that concluded on 13 May 2026. **The medical cause of death was:** **1a Prosthetic Aortic Valve Thrombosis with Sub-Therapeutic Anti-Coagulation** **2 Turners Syndrome** Lacey Carole Anne HEATH died on 16 February 2025 at Lynfields, London Road, Witham of Prosthetic Aortic Valve Thrombosis with Sub-Therapeutic Anti-Coagulation en-route following a collapse at home. Miss Heath had Turner's Syndrome and had a bicuspid valve and was at higher risk of developing cardiac problems. Miss Heath underwent successful surgical replacement of her Aortic Valve, aortic root and ascending aorta in May 2019 and was prescribed anticoagulation. Miss Heath was a medically complex patient with warfarin resistance. There was difficulty maintaining anticoagulation within a therapeutic range that was managed by the local hospital that were not resolved with medication changes. In January and February 2025 anticoagulation was noted to be sub-therapeutic. Miss Heath was found on the morning of 16 February 2025 with rapid respiration and unresponsive. Miss Heath went into cardiac arrest en-route to hospital and ambulance crew stopped and commenced resuscitation with escalation to critical care support. HEMS continued with advanced life support upon arrival, but Miss Heath had complete stenosis of her mechanical valve with thrombosis that caused the cardiac arrest that was irreversible **Conclusion** Miss Heath was at significant risk of developing thrombus on her mechanical aorta valve as a recognised complication of necessary medical treatment. The risk increased when required anticoagulation was sub-therapeutic, and that contributed to her death.
8.	**CIRCUMSTANCES OF DEATH** Lacey Carole Anne HEATH died on 16 February 2025 at Lynfields, London Road, Witham of Prosthetic Aortic Valve Thrombosis with Sub-Therapeutic Anti-Coagulation en-route following a collapse at home. Miss Heath had Turner's Syndrome and had a bicuspid valve and was at

	higher risk of developing cardiac problems. Miss Heath underwent successful surgical replacement of her Aortic Valve, aortic root and ascending aorta in May 2019 and was prescribed anticoagulation. Miss Heath was a medically complex patient with warfarin resistance. There was difficulty maintaining anticoagulation within a therapeutic range that was managed by the local hospital that were not resolved with medication changes. In January and February 2025 anticoagulation was noted to be sub-therapeutic. Miss Heath was found on the morning of 16 February 2025 with rapid respiration and unresponsive. Miss Heath went into cardiac arrest en-route to hospital and ambulance crew stopped and commenced resuscitation with escalation to critical care support. HEMS continued with advanced life support upon arrival, but Miss Heath had complete stenosis of her mechanical valve with thrombosis that caused the cardiac arrest that was irreversible
9.	**CORONER'S CONCERNS** During the course of the inquest I heard evidence giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: 1. **Ms Heath was noted to be warfarin resistant and alternative medication regimes were not successful in keeping Ms Heath within a therapeutic range for her required lifelong requirement to have anticoagulation to prevent a significant risk of death. The GP and hospital clinicians trailed different combinations of appropriate therapy which included additional injections when required. This was not considered to be clinically appropriate long-term.** 2. **Due to the complexity of her case, Ms Heath's anticoagulation was under the care of the acute hospital team. Alternative anticoagulation medication had resulted in high INR readings and significant risks associated with bleeding.** 3. **Ms Heath's experienced clinical team did not consider that there had been a sufficient trial of Warfarin and recommended at-home monitoring to permit daily readings to be taken to manage the significant risks associated with anticoagulation and to find an individualised dose for Ms Heath. Clinicians were not concerned about medication non-compliance and that the difficulties were clinical.** 4. **Ms Heath could not afford to fund the at home monitor as this was financially prohibitive for her being on a low income. The monitor was expensive and there is no obligation for General Practitioners to fund the testing strips and incidentals required to facilitate testing. As this would be a lifelong commitment for a woman who was only 34 years-old, Ms Heath was not able to take the advice of her expert clinical team and was compelled to have alternative prescribing that was not successful in keeping her INR within therapeutic range.** 5. **No application for funding was made on behalf of Ms Heath by the Trust nor was this explained to Ms Heath who a very quiet, shy lady who always relied on her very loving family to assist her with appointments and could not advocate for herself. There was no consideration if Ms Heath had any learning difficulties and it was noted that there was developmental delay in her medical records. Evidence at the inquest was Ms Heath experienced this as clinicians not caring about her and she became very despondent about the failure to achieve a therapeutic range.**

	6. Ms Heath did not manage to achieve a therapeutic INR for a protracted period of time putting her at increased risk of developing complications and did have a medical review or a haematology referral. **7. There was an absence of appropriate medical records recorded for Ms Heath to understand her clinical presentation other than very basic information on the INR platform on INR results and medication dose. Evidence was these records are not compliant with the requirements of healthcare regulators and led to a lack of appreciation of Ms Heath's concerns and the complexity of her case. One entry stated Ms Heath had been "unwell" with no clarification or further information on what the problem was and/or how this may have impacted on her condition.**
10.	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: 1. Care Quality Commission I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
	SIGNATURE [redacted]