REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Chief Executive Rochdale Metropolitan Borough Council 2. Chief Executive Care Quality Commission 3. [redacted] Owner/Proprietor, Passmonds Care Home, Rochdale
1	**CORONER** I am Mrs L J Hashmi, Assistant Coroner, for the coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On the 11th July 2013, I commenced an investigation into the death of Derrick George RIVERS then aged 89 years of Passmonds Care Home, Edenfield Road, Rochdale, Greater Manchester. The investigation was concluded at the end of the inquest on the 28th February 2014. The conclusion of the inquest was narrative: '...the deceased died as a result of natural causes, to which the administration of Clozapine may have contributed...' The medical cause of death was 1a) Ischaemic Heart Disease
4	**CIRCUMSTANCES OF DEATH** The deceased had become increasingly frail and following a fall, a decision was taken to arrange his admission to full time care. Initially, Mr Rivers settled well and was able to self-medicate. However, shortly after admission the care home staff felt that he could no longer manage this aspect of his care independently and assumed responsibility for the task. On the morning of the 3rd July 2013, the senior carer was engaged in the process of administering medications to residents. During the course of the round she erroneously administered a 150mg dose of Clozapine to the deceased. This was an anti-psychotic medication meant for another resident; it was not a controlled drug but was treated as such by the care home staff due to its potency. The error was noted immediately and the emergency services summoned. The deceased was admitted to hospital suffering from altered level of consciousness and confusion. After a number of days the Mr Rivers showed improvement in his overall condition and discharge planning was set in motion. Unfortunately, in the early hours of the 11th July he deteriorated and died later the same day. A forensic post mortem examination was carried out. The Dr concluded that the deceased died of natural disease process. However she was not able to completely exclude the possibility that the dose of Clozapine had not exacerbated this (thus hastened death). Furthermore, it was evident at post mortem that the deceased had a degree of liver impairment. Given this, the Dr concluded that it was possible that the deceased's body systems may have taken longer to clear the drug. The care home and Local Authority Adult Safeguarding Team carried out their own investigations. The carer was demoted for failing to follow the care home's protocols on drug administration. The Chair of the Case Conference concluded that it was the consensus of the case conference that there had been 'physical' abuse and there was a majority consensus as to 'institutional abuse' – as defined within the strict terms of its definitions.. The Care Home owner reluctantly accepted the former but not the latter.

(Head of Medicine Management at the Clinical Commissioning Group, who was invited by the Local Authority to assist in the investigation process) gave evidence that the drug administration policy used by the care home was inadequate and a number of patient safety issues were identified when he inspected on the 5th July 2013. Immediate recommendations were made. Whilst some remedial actions were taken, not all his recommendations had been implemented by the time of his second inspection on the 5th September 2013. considered that further work needed to be done to reduce the future risk of maladministration of medicines – both at the care home and borough-wide.

also stated that whilst the CQC is able to carry out medication reviews as part of its inspection process it had not done so as part of its most recent inspection of the care home. Had it done so, opined that the situation involving Mr Rivers might have been avoided. He was of the view that subsequent inspections should not only address Outcome 9 but also that the medication audit should be conducted on an annual basis.

concluded by saying that the dose of Clozapine administered was more than ten times the normal starting dose of 12.5mg and that given its potency, the potential for harm from a 150mg dose was high and would, in his view, have had catastrophic consequences – even for someone much younger than the deceased.

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:-

1) That the Local Authority and/or CQC, following their recent inspections of the care home, had not noted the inadequacies of the care home's drugs policy/drug administration protocol.

2) That not all CQC Outcomes were considered at the last inspection, purportedly because they did not have anyone available to inspect and review the drugs administration system at the material time.

3) That the care home owner and/or manager were purportedly unaware of the fact that carers were not following drugs administration protocols.

4) That the care home had little, if any, audit processes in place.

5) That the care home's drugs administration protocol was not fit for purpose and was tantamount to a 'hybrid' of other policies i.e. it was not specific to the care home environment.

6) That the care home's policy did not meet the pharmacy requirements in terms of patient and drug identification (pod system).

7) That the care home owner and/or manager did not act upon all recommendations made by after the event, in a timely manner. Risks therefore remain.

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.

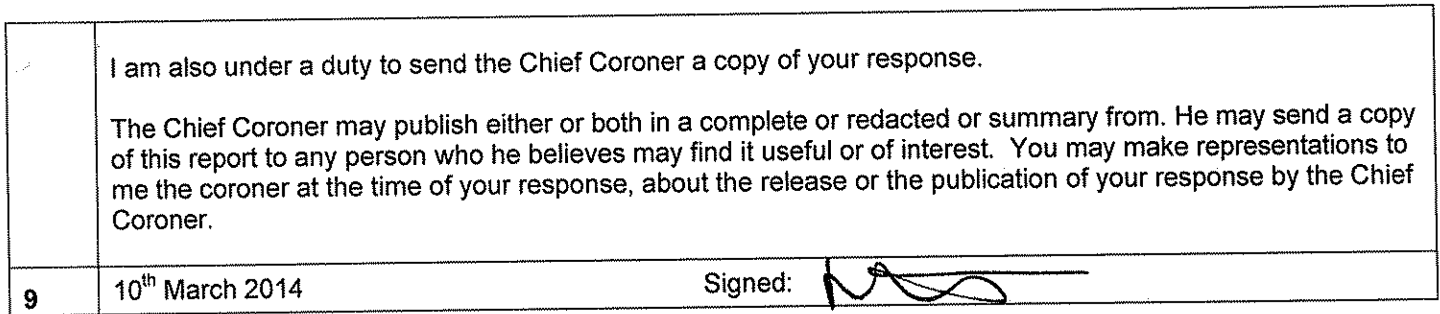
7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely Monday 5th May 2014. I, as Assistant 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 namely the family of the deceased.



	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 from. 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	10th March 2014 Signed: