

H M Senior Coroner for Gloucestershire Ms Katy Skerrett

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO: Barchester Homes c/o Radcliffes Le Brasseur, 85 Fleet Street, London EC4Y 1AE
1	CORONER
	I am Katy Skerrett, Senior Coroner for Gloucestershire.
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 the 28 th March 2017 I commenced an investigation into the death of Ronald Maurice Brewer. The investigation concluded at the end of the inquest on the 18 th October 2017. The conclusion of the inquest was death by industrial disease. The medical cause of death was 1A morphine & midazolam toxicity, 2 chronic asbestosis of lungs, epitheliod mesothelioma.
4	CIRCUMSTANCES OF THE DEATH
	Mr Brewer was an 87 year old man with a significant medical history including atrial fibrillation, Parkinsons, and mesothelioma. On the 10 th March 2017 he was admitted to hospital as an emergency with shortness of breath and pleural effusion. Clinicians advised for best supportive care, and on the 17 th March 2017 he was discharged to Badgeworth Court Care Home for end of life care. On the 22 nd March 2017 he was administered his prescribed palliative care medicines together with an anticipatory medication also prescribed. Mr Brewer passed away shortly thereafter.
5	CORONER'S CONCERNS
	During the course of the inquest the evidence revealed matters giving rise to concern. Whilst I did not find them causal in Mr Brewer's case, 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 MATTER OF CONCERN is as follows. — 1. The administration of medications, including in particular the documentation of and dispensation of palliative medications.
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 4pm 13 th December 2017. 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.

Ì	8	COPIES and PUBLICATION
		I have sent a copy of my report to the Chief Coroner and to the following Interested Persons (1) Garranturton, Kilmacthomas, Waterford, Co Waterford, Ireland X42 P489 (2) Inspector Gloucestershire, Adult Social Care Directorate, CQC South Region, CQC South West, Citygate, Gallowgate, Newcastle upon Tyne NE1 4PA
		I am also under a duty to send the Chief Coroner a copy of your response.
The second secon		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	Dated 19 th October 2017
		Signature
		Ms K Skerrett
ı		Senior Coroner for Gloucestershire