REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Secretary of State for Health
1	CORONER I am Alison Mutch, Senior Coroner, for the coroner area of South Manchester
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 18th September 2017 I commenced an investigation into the death of Joan Wright. The inquest concluded on the 12th December 2018 and the conclusion was one of **Natural Causes** The medical cause of death was **1a) Acute myocardial insufficiency; 1b) Coronary artery atheroma**
4	Joan Wright resided at Belmont Residential Home. She had poor mobility and was unable to verbally communicate. The Care Home was rated inadequate in January 2017. It was subject of ongoing intervention in relation to implementation of an action plan. On 25th August 2017 it was identified she had been given Oramorph incorrectly in the preceding days. She was not seen by a GP. On 16th September 2017 she died at Belmont Residential Home. Post-mortem examination found that she had extensive coronary artery atheroma which had caused her death.
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. The inquest heard that Oramorph has different classifications depending on the strength prescribed. This impacts the storage/handling arrangements. The inquest heard that opioids can have a significant impact at whatever strength they are prescribed if given in excess; 2. Evidence was given that because of the abolition of PCT and replacement with CCG's there was no designation of the CCG's as designated bodies with statutory responsibility in relation to drugs. This was an oversight but has not been corrected; 3. Following the maladministration of medication to Mrs Wright, the inquest heard that the matter was reported to GMP .The CDLO investigated but did not liaise with the local police unit or discuss the safeguarding implications; 4. GMP's call handler did not recognise the potential safeguarding risks of the maladministration of opioids to a vulnerable member of the community and referred the report to the local division. The local division assessor (LRO) failed to recognise the safeguarding risks and filed the report as theft. GMP have changed their policies significantly since the matter was referred to them after Mrs Wright's death. However it was unclear about whether or not the issue had been addressed by Forces nationally. The inquest was told that the CDLO role had been brought in after the Shipman inquiry to ensure safeguarding risks were identified in relation to maladministration of drugs; 5. The home in question has been rated as inadequate by CQC and was under regular monitoring via an action plan. It was also being visited regularly by the Local Authority Quality Support Team every 10 days or so. One of the issues previously identified was poor management/documentation of medication. Notwithstanding that, access and unauthorised repeated administration of Oramorph took place; 6. The CQC gave evidence that the legislation requires regular checks by care homes in relation to medication but there is no statutory definition of what regular means. As a result in some it is monthly in others weekly.
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 22nd February 2019. 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 namely 1) [redacted] daughter of the deceased 2) Greater Manchester Police 3) Stockport Metropolitan Borough Council 4) Care Quality Commission 5) Stockport Clinical Commissioning Group 6) [redacted] who may find it useful or of interest. 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	**Alison Mutch OBE** **HM Senior Coroner** **28.12.2018**