REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **(1) Royton & Crompton Family Practice** **(2) [redacted] (Home Manager), Edge Hill Residential Home** **(3) Pennine Care NHS Foundation Trust** **(4) Clinical Commissioning Group (Oldham)**
1	**CORONER** I am, Rachel Galloway, assistant 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 the 29th April 2019 I commenced an investigation into the death of Miriam Tighe. The investigation concluded on the 2nd May 2019 where I left a narrative conclusion: *"Miriam Tighe died as a consequence of naturally occurring disease, exacerbated by high levels of sedation and immobility in the months prior to her death, which worsened her underlying frailty"* The medical cause of death was recorded as: **1a) Vascular Dementia** **II) Old age; Frailty**
4	**CIRCUMSTANCES OF THE DEATH** In August 2016 Miriam Tighe became a resident at Edge Hill Residential Home, 315 Oldham Road, Oldham following a period of hospital admission at the Royal Oldham hospital. After a short time, she appeared to settle at the home. In late October 2016, Miriam Tighe was noted to be experiencing episodes of aggression and agitation and various medications were prescribed from that time in an effort to address her symptoms. Different medications with sedative effect were prescribed by GPs and by the Psychiatrist. Mrs Tighe continued to receive Promazine medication after the Psychiatrist had advised that this should be stopped on the 16th November 2016 and again on the 16th December 2016. From November 2016, Mrs Tighe was regularly over-sedated, leading to increased immobility and deconditioning. Immobility was further contributed to by limited stimulation and the promotion of a sedentary lifestyle by staff under the instruction of the home manager. In turn, this contributed to and worsened Miriam Tighe's underlying frailty. On the 30th December 2016 Miriam Tighe was sedated with promazine. After consultation with the GP, an ambulance was called and she was taken to ROH. The home manager refused to accept Miriam Tighe back at the home on the basis that an EMI nursing bed was

	required. MT was admitted to hospital whilst an EMI bed was found. On the 6th February 2017 she was discharged into the care of Kings Park Residential Home, Kings Road, Ashton-Under Lyne for nursing care. On the 19th February 2017 she was admitted to Tameside Hospital. Miriam Tighe remained in hospital and received palliative care until she passed away on the 28th February 2017.
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. – Promazine was sought by the home manager at Edge Hill Residential Home and prescribed by the GPs at Royton & Crompton family practice after [redacted] (Psychiatrist working in the Memory Clinic (part of Pennine Care NHS Foundation Trust)) had advised that such medication be stopped on the 16th November 2016 and, again on the 16th December 2016. On both occasions, promazine continued to be prescribed by the GP and continued to be administered under the control of the manager at Edge Hill Residential Home. In the event, I found that Miriam Tighe had been over-sedated during her time as a resident at Edge Hill Residential Home. The psychiatrist had recommended alternative sedative and antipsychotic medication, which was also being administered to Miriam Tighe. It was clear that the GPs and the Psychiatrist were not aware of decisions being made by each other In October to December 2016, which led to unsafe prescribing of sedatives and antipsychotic medication.
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 29th August 2019. I, the 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 following Interested Persons namely (1) [redacted] (2) [redacted] (3) [redacted] (4) Edge Hill Residential home, (5) Pennine Care NHS Foundation Trust, 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	**Rachel Galloway** **HM Assistant Coroner** **04.07.2019**