REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: Dr Ian Hudson, Chief Executive, Medicines Healthcare products Regulatory Agency, 10 South Colonnade, London E14 4PU.

CORONER

I am Chris Morris, Area Coroner for Manchester South.

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.
http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7
http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST

On 7th November 2018, an inquest was opened into the death of Irene Collins who died on 16th June 2018 at Firbank House Residential Home, Ashton-under-Lyne aged 78 years. The investigation concluded with an inquest which I heard between 22nd-24th July 2019 and which concluded with a Narrative Conclusion to the effect that Mrs Collins died as a consequence of obtaining and ingesting a latex glove whilst unsupervised at her care home.

CIRCUMSTANCES OF THE DEATH

Mrs Collins was formally diagnosed with dementia in 2015. Following the sudden death of her husband in 2017, she was assessed as requiring full-time residential care and after a brief period in another establishment, moved into Firbank House Residential Home.

By this time Mrs Collins' health problems had become complex and significant and included Type 2 Diabetes, Chronic Obstructive Pulmonary Disease, low mood, Ischaemic Heart Disease, Chronic Kidney Disease stage 3 and macular degeneration, in addition to dementia.

Over the final months of Mrs Collins' life, her dementia became advanced and she developed an appreciable propensity to insert foreign objects into her mouth.

On 16th June 2018, Mrs Collins was found dead in a chair in the communal lounge of the care home. At post mortem examination, a pathologist acting on behalf of the coroner found a latex clinical examination glove in Mrs Collins' proximal trachea / larynx.

The examination was stopped and a forensic post mortem examination then took place. The conclusion of the Home Office pathologist was that Mrs Collins died as a consequence of:-

1a) Upper airway obstruction;
2) Multi-infarct dementia.

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. –

The court heard evidence that at Firbank House, there was unrestricted access to clinical examination gloves and other personal protective equipment intended to be used by those delivering care from wall-mounted dispensers in corridors. Additionally, at that time, once used the clinical examination gloves could be disposed of in a variety of bins, which were again easily accessible to residents.

Whilst significant steps have now been undertaken at Firbank House to restrict the access of clinical examination gloves to residents with cognitive impairment, it is a matter of concern that in many settings where care is provided to vulnerable people, they are extremely easy to access.

It is considered an alert or authoritative guidance as to the storage and disposal of clinical examination gloves in care settings may prevent future deaths.

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by **14th November 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to [redacted] on behalf of the family, together with Weightmans LLP as the legal representatives of Firbank House Residential Home.

I have also sent a copy to the Care Quality Commission, 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.

Dated: 19th September 2019.

Signature: Chris Morris HM Area Coroner, Manchester South.