REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Chief Executive of the Care Quality Commission (CQC)
1	CORONER I am Alison Mutch, Senior Coroner, for the Coroner Area of Greater Manchester South
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 9th July 2019, I commenced an investigation into the death of Elaine Renshaw. The investigation concluded on the 6th January 2020 and the conclusion was one of **Accidental Death**. The medical cause of death was **1a) Myocardial infarction, on a background of drug toxicity.**
4	CIRCUMSTANCES OF THE DEATH Elaine Rose Renshaw worked at a care home and was found unresponsive at her home address. She was resuscitated by paramedics and taken to Tameside General Hospital. At Tameside General Hospital attempts to reverse the effects of morphine continued. They were unsuccessful and she continued to deteriorate. On 8th July 2019, she died at Tameside General Hospital. The care home where she worked identified that checks on controlled drugs had not been accurate and controlled drugs had been incorrectly accounted for. Blood samples taken by the hospital were analysed. The concentration of total morphine (that is morphine itself and morphine metabolites) in her blood sample was within the range encountered in individuals receiving morphine chronically (e.g. for palliative care). However, it was equally within the range encountered in fatalities associated with use of morphine even in chronic and therefore tolerant users.
5	<u>CORONER'S CONCERNS</u> 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. – During the course of the inquest evidence was given that controlled drug checks processes had been such that it was not easily identified that drugs were not accounted for e.g. Stock sheets were inaccurate. The home in question had tightened up its processes since the incident. However the inquest heard that this issue may well arise in the future in other care/nursing home settings as there is no clear process for handling/recording the use of controlled drugs.
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 21st April 2020. 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] husband of the deceased; 2) Manchester City Council, 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** **25.02.2020**