C.G.BUTLER
SENIOR CORONER · BUCKINGHAMSHIRE

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Carewatch (Mid Bucks)**
1	**CORONER** I am CRISPIN GILES BUTLER, Senior Coroner for the coroner area of Buckinghamshire
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. http://www.legislation.gov/uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/pdfs/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 4th April 2019 I commenced an investigation into the death of Heather Beatrice Planner, aged 87 years. The investigation concluded at the end of the inquest on 20th November 2019. The narrative conclusion of the inquest was that Mrs Planner died from natural disease to which a stroke caused by the effects of not receiving her prescribed anticoagulation contributed more than minimally.
4	**CIRCUMSTANCES OF THE DEATH** The medical cause of death established was: 1a Large bowel ischaemia leading to gastrointestinal bleed 1b Peripheral vascular disease 2. Left frontoparietal lobe infarct, atrial fibrillation, ischaemic heart disease, hypertension The circumstances were that Mrs Planner died on 1st April 2019 at Wycombe Hospital as a result of a gastrointestinal bleed. This was against a background of large bowel ischaemia and in the context of a stroke which occurred after Mrs Planner had not received her prescribed apixaban anticoagulation at home over the two days prior to her admission to Stoke Mandeville hospital on 27th February 2019. Carewatch (Mid Bucks) were the providers of individual carers who administered medication from a dossette tray which was labelled for a different patient and which

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	contained the medication for that other patient, rather than Mrs Planner's specific medication.
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 could 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) Changes to an individual patient's medication are emailed to carers and a new prescription (MAR) chart is issued but there is no procedure in place to ensure that individual carers have read and specifically acknowledged any medication changes. (2) It is unclear what additional measures or cross-checking have been introduced to prevent a subsequent carer, who is attending a patient, from inheriting a medication error from an earlier attendance and repeating that error. (3) There does not appear to be any process for individual carers to sign to acknowledge having read and implemented a patient's care plan in the patient's log book. (4) There does not appear to be a system for recording on a patient's records specific medication instructions or changes to medication which might have been given or taken by mobile phone. (5) There does not appear to be any electronic system or record to enable carers to access a patient's medication history, the records at the patient's home being only paper records. (6) There is a specific concern in Mrs Planner's case about the robustness of the subsequent Carewatch investigation and any learning that would arise to prevent incidents in the future, since Carewatch had not procured the original paper patient records from Mrs Planner's home address at any stage during their investigations or prior to the inquest hearing. This may have compromised the ability to assess the accuracy of records to which the individual carers had access, any impact that may have had upon the medication error, or any learning to arise in the context of record keeping and application of medication and care plan requirements by carers.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action.

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7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 7th February 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: The Family of Heather Planner Westongrove Partnership I have also sent it 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.
9	**13th December 2019** **Crispin Giles Butler, Senior Coroner for Buckinghamshire**

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