REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: **Medicines and Healthcare products Regulatory Agency and NHS Stockport Clinical Commissioning Group**
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 17th November 2020 I commenced an investigation into the death of Ian Hall. The investigation concluded on the 3rd June 2021 and the conclusion was one of Narrative: Died from aspiration pneumonia following a choking incident after admission following a fall in combination with Covid-19 pneumonitis. The medical cause of death was 1a Aspiration pneumonia on a background of a choking incident, Covid-19 pneumonitis; II Alzheimer's dementia

4	CIRCUMSTANCES OF THE DEATH Ian Hall had Alzheimer's and was vulnerable. He had carers in the community. He was admitted to Stepping Hill Hospital on 27th October following a fall. No injuries resulted from the fall. On 28th October during a post admission medicines reconciliation check at Stepping Hill Hospital it was identified that in the community he had been dispensed by the community pharmacy Amitriptyline rather than Atenolol which was on his prescription. Amitriptyline would have led to increased drowsiness and an increased falls risk. On 28th October he choked on medication. He subsequently developed aspiration pneumonia and was treated but continued to deteriorate. On 2nd November a Covid-19 swab was positive. He was treated for Covid-19 but deteriorated further. On 14th November 2020 he died in Stepping Hill Hospital from a combination of aspiration pneumonia and Covid-19 pneumonitis.

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. – 1. It was unclear how Amitriptyline rather than Atenolol had been dispensed in the community. 2. It was unclear what checks the pharmacy in question had or any pharmacy has to avoid the inadvertent dispensing to a vulnerable adult where the carers role is to administer whatever medications are collected from the pharmacy in the name of the individual. The inquest was told that the carers in this situation generally will have no clinical training. Therefore, their role is to check the medication is in an individual's name and give it to the individual in compliance with what is on the label. It is not part of their role to cross check previous medications or query changes to 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 9th August 2021. 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, [redacted] (family of the deceased), 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	**14th June 2021**  **Alison Mutch HM Senior Coroner Manchester South**