REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Managing Director of Cherish Home Care, 5 St Michale's Court, Victoria Street, West Bromwich, B70 8ET** **2. CQC- copied in for information only.**
1	**CORONER** I am Zafar Siddique, Senior Coroner, for the coroner area of the Black Country.
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 28 March 2021, I commenced an investigation into the death of Ms Karen Redding. The investigation concluded at the end of the inquest on 28 October 2021. The conclusion of the inquest was a short form conclusion of open conclusion: The cause of death was: 1a Multidrug Toxicity II Ischaemic Herat Disease, Diabetes, Chronic Kidney Disease
4	**CIRCUMSTANCES OF THE DEATH** i) Ms Karen Redding (KR) was first started on morphine sulphate solution (Oramorph) on 19 November 2019. ii) The orampprph medication was for management of pain relief after a leg amputation. Her initial dose was [redacted] to be taken up to four times daily. iii) On 6 August 2020 the dose of Oramorph was then increased to [redacted] times daily when KR reported worsening pain from her stump. iv) The last prescription for Oramorph issued by the GP practice was on 13 January 2021. Her previous supply had lasted since the 3 November 2020 and she told her GP that she was using the Oramorph for 'breakthrough pain'. v) On the 24 March 2021, KR requested that a member of the care staff pass her a box that was placed near her in her room. This box contained a bottle of oramorph medication. KR subsequently drank around [redacted] of oramorph. vi) Later that afternoon further care staff visited, and KR told them she had

	taken "a little too much" oramorph. vii) She became increasingly drowsy and sadly died from the fatal overdose.
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. – 1. Evidence emerged during the inquest that KR was handed the oramorph medication by the care staff upon her request. It appears that there was no check made of the contents of the box. 2. KR subsequently disclosed that she had taken an excess of oramprph solution. 3. Although, she declined any help and said she would prefer to rest and "sleep it off", it may well have been appropriate to have her seen by a Doctor.
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. 1. The care staff management team may wish to consider reviewing their training and guidance to care staff, particularly when handing items to the patient and checking contents of boxes. 2. The care staff management team may wish to also consider their policy of escalation to emergency services in these circumstances when it was established the patient had taken an overdose of oramorph.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 17 January 2022. 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; Family. 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	**18 November 2021**

	Mr Zafar Siddique **Senior Coroner** **Black Country Area**