REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** Dr Jackie Bene, Chief Executive Trust Headquarters, Royal Bolton Hospital, Minerva Road, Farnworth, Bolton, BL4 0JR
1	**CORONER** I am Alan Peter Walsh, Area Coroner for the Coroner Area of Manchester West
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 7th January 2015 I commenced an Investigation into the death of Maureen Chatterley (formerly known as Maureen Hinckley), 68 years, born 15th September 1946. The medical cause of death was 1a) Bronchopneumonia, 1b) Chronic Obstructive Pulmonary Disease, 2) Coronary Artery Atherosclerosis and infected right hip following fracture of neck of right femur. The conclusion of the Inquest was Maureen Chatterley died as a consequence of naturally occuring disease exacerbated by injuries sustained in an accidental fall and recognised complications arising from the treatment of her injuries.
4	**CIRCUMSTANCES OF THE DEATH** 1. Maureen Chatterley died at the Royal Bolton Hospital, Minerva Road, Farnworth, Bolton on the 24th December 2014. 2. On the 27th August 2014 Mrs Chatterley had a fall at her home address at [redacted] sustaining a fracture of the neck of femur of the right hip. She was taken to the Royal Bolton Hospital, Bolton and on the 29th August 2014 she had surgery to repair the fracture. Mrs Chatterley was discharged from the hospital on the 1st September 2014 but she was re admitted to the hospital on the 4th October 2014 with a dislocated prosthesis of the right hip. The hip was manipulated to reduce the dislocation and Mrs Chatterley was discharged from the hospital on the 6th October 2014. On the 9th October 2014 Mrs Chatterley suffered a further dislocation of

the hip and she was admitted to the Royal Bolton Hospital where she had surgery on the 9th October 2014 and the 13th October 2014 when the prosthesis was removed. Mrs Chatterley had further surgical procedures on the 4th November 2014 and the 18th November 2014 to explore the hip and to carry out wash outs of puss and a haematoma.

3. From the 9th October 2014 until the 24th December 2014, when Mrs Chatterley died, she was treated with antibiotics and other medications including Loperamide for irritable bowel and Lorazepam for anxiety and agitation. The dose of Lorazepam, which was commenced in December 2014, was prescribed as "PRN dose of 0.5mg to a maximum 1mg in 24 hours".

4. On the 14 December 2014 the family was concerned that 2 x 1mg of lorazepam was given as a single dose and the family informed a Doctor and the nursing staff of their concerns in relation to the excess dose. The medication chart did not indicate that an excess dose of Lorazepam had been administered and the medication chart showed that the correct dose had been administered. However there was no investigation in relation to the family's concerns and the number of Lorazepam tablets in Mrs Chatterley's medication drawer was not checked at the time

5. On the 14th October 2014 Mrs Chatterley was transferred from Ward G4 to Ward G3, which is the Trauma Stabilisation Unit.

   Evidence was heard at the Inquest from a consultant nurse and from the ward manager in relation to medication prescribed to Mrs Chatterley whilst she was treated on Ward G3.

   The evidence referred to the fact that medications would be prescribed by a doctor and obtained either from the pharmacy in the hospital or from a stock of medication kept in a cupboard on the ward. The medication would be requested and obtained by the by the nursing staff and the medication would be placed in a medication drawer allocated to the patient.

   The control of medication depended upon whether the medication was a controlled drug or a non-controlled drug. In relation to non-controlled drugs, which included Lorazepam, a stock was kept in a cupboard on the ward and a nurse would obtain the medication from the stock in the cupboard and place the medication in the allocated medication drawer.

   The number of tablets placed in the allocated medication drawer are not counted, either individually or by the box, when they are placed in the medication drawer and, on occasions, an unidentified number of tablets from opened boxes are placed in the drawer.

   When Mrs Chatterley was prescribed Lorazepam the nurse obtained the Lorazepam tablets from the cupboard on the ward and placed an unknown number of tablets into the medication drawer allocated to Mrs Chatterley. However there was no record of the number of tablets placed in the medication drawer allocated to Mrs Chatterley and there

was no stock record or control of the tablets remaining in the cupboard on the ward. Accordingly the evidence confirmed that there was no record of the number of tablets in the medication drawer nor the cupboard on the ward at any point in time.

6. The ward manager gave evidence that there may be over 100 medications supplied to patients on Ward G3 and it would be impossible to keep a record of the number of tablets either in the medication drawers or the cupboard on the ward.

7. The conclusions of the Inquest accepted that any excess dose of Lorazepam tablets did not play a part in the cause of death but it was accepted that, although there was no direct evidence of the administration of an excess dose, the concerns of the family had not been investigated and the administration of an excess dose of the medication could not be excluded.

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. During the Inquest evidence was heard that

   i. There was no investigation by the hospital in relation to the concerns expressed by the family in relation to the administration of an excess dose of Lorazepam.

   ii. There was no record of the stock of medication in relation to non-controlled drugs in the medication drawer allocated to a patient nor in and the medication cupboard on the ward. Accordingly medication could be removed from the medication cupboard on the ward and used either for an elicit purpose or excess dosage without any knowledge or record with reference to stock control.

   Evidence was given at the Inquest that the pharmacist checked medications on the ward on a daily basis but there was no check or record of the number of medications or the number of tablets in the allocated medication drawers or the cupboard on ward, particularly between the daily inspections by the pharmacist.

2. I request you to consider the above concerns and try carry out a review with regard to the following:

   i. The procedures in relation to the supply, security and safe keeping of medication on wards at the Royal Bolton Hospital.

	ii. Stock control and a record of medications both in the medication drawers allocated to individual patients and in cupboards on wards at the Royal Bolton Hospital to enable the medications and the quantities of medications to be identified and verified, both in the medication drawers and in the cupboards on the ward, at any point in time. iii. The evidence raised concerns that there is a risk that future deaths will occur unless action is taken to review the above issues.	
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe you and your organisation 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 2nd December 2015. 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 1. [redacted] Mrs Chatterley's Husband 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	**Dated** **8th October 2015**	**Signed** **Mr Alan P Walsh**