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. [REDACTED] The Managing Director of Cuerden Care Homes, Unit 6 Beecham Court, Wigan, WN3 6PR
1	**CORONER** I am Rachael Clare Griffin, Assistant 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 the 11th December 2015 I commenced an investigation into the death of Betty Addison, born on the 1st December 1925. The investigation concluded at the end of the Inquest on the 12th February 2016. The Medical Cause of Death was: 1a Bilateral Pulmonary Embolism 1b Deep Vein Thrombosis 1c Immobilisation following fracture of right neck of femur (operated on) The conclusion of the Inquest was that Betty Addison died as a consequence of immobility following the injuries sustained in an accidental fall and the subsequent surgical treatment of those injuries.
4	**CIRCUMSTANCES OF THE DEATH** On the 14th October 2015 the deceased, who was usually very mobile for her age, fell whilst walking for the bus sustaining a fracture to her right neck of femur. She was taken to the Royal Albert Edward Infirmary, Wigan where the fracture was surgically repaired on the 15th October. She was discharged from hospital to Alexandra Court Care Home, Wigan on the 24th October for rehabilitative care and later transferred to Alexandra Grange Care Home, Howard Street, Pemberton, Wigan on the 26th November. On the 2nd December she collapsed in her room at Alexandra Grange Care Home and died.

5	**CORONER'S CONCERNS**

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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:

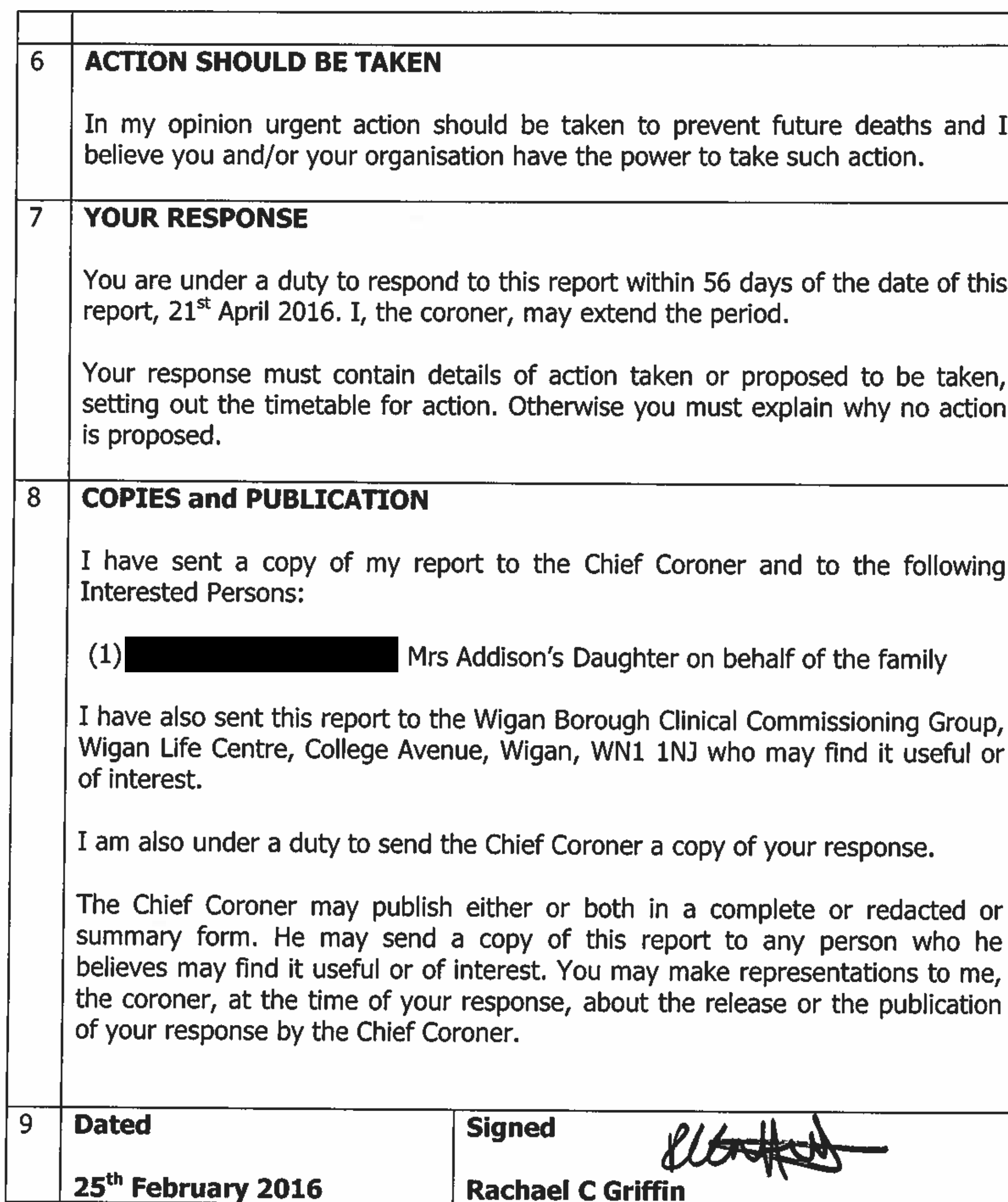
   i. As a result of the surgical treatment Mrs Addison received at the Royal Albert Edward Infirmary, Wigan on the 15th October 2015, she was given prophylactic treatment in line with hospital policy in order to reduce the risks of a deep vein thrombosis occurring following the surgery. As part of this treatment Mrs Addison was prescribed Dalteparin which is a low molecular weight heparin administered by injection. This medication was started on the 14th October 2015 and she was prescribed sufficient medication upon her discharge for the injections to continue until the 17th November 2015.

   ii. From the records relating to Mrs Addison's care at the Alexandra Court Care Home, Mrs Addison continued to be given Dalteparin injections until the 22nd November 2015. She therefore received an additional 5 injections than was prescribed to her. Mrs Addison left the Royal Albert Edward Infirmary with 24 injections and from the evidence given at the Inquest it was not known where the additional 5 injections had come from, or why they were given to Mrs Addison. It was confirmed at the Inquest that these injections had been incorrectly given to Mrs Addison. From the evidence at the Inquest it was clear that this additional medication was not causative or contributory to Mrs Addison's death, however she was given medication that she should not have been.

2. I have concerns with regard to the following:

   i. The administering of medications at Alexandra Court Care Home is not sufficiently controlled and other residents at the Home may be given medication other than in accordance with that prescribed, whether that is an excessive amount, or a reduced amount, as the 5 injections given to Mrs Addison must have come from somewhere and potentially another resident's supply.

   ii. I therefore request that a review be conducted by Cuerden Care Homes of the policies and procedures adopted by Alexandra Court Care Home in relation to the administering and monitoring of medication in order to ensure the correct mediation is given to residents as administering incorrect mediation can lead to a death.



6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe you and/or 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, 21st April 2016. 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 Addison's Daughter on behalf of the family I have also sent this report to the Wigan Borough Clinical Commissioning Group, Wigan Life Centre, College Avenue, Wigan, WN1 1NJ 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	**Dated** **25th February 2016**

Signed
Signed **Rachael C Griffin**