REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** [redacted], Managing Director, Persona Care and Support Ltd. **2.** Bury Metropolitan Borough Council
1	**CORONER** I am Ms L J Hashmi, Area Coroner for the Coroner area of Manchester North.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On the 5th March 2018 I commenced an investigation into the death of Dr Donald Clegg. This concluded by way of inquest on the 7th August 2018, having been adjourned part-heard from the 26th June 2018.
4	**CIRCUMSTANCES OF DEATH** Against a backdrop of deteriorating physical and mental health, including a complex neurological condition, chronic alcohol issues, depression, hypertension and asthma, the deceased was admitted to an intermediate care placement. When that placement came to an end after a 6 week period, he was transferred to another 24-hour short-term residential placement on the 26th January 2018. Soon after transfer, it became apparent that the establishment in question could not manage his care needs. There had been no face to face assessment of the deceased's suitability for this placement and communication between the care placement teams was inadequate. Assessment was based upon a brief questionnaire completed by an Administrator. Whilst the deceased was known to take excessive amounts of medication of his own volition (Co-Codamol), he was deemed by staff to have sufficient capacity to make his own decisions and was therefore allowed to continue to self-medicate. Whilst staff at the placement knew, or ought to have known, of the deceased's propensity to regularly take higher than prescribed doses of Co-Codamol, it was not until the 22nd February 2018 that staff discovered that a significant quantity of Co-Codamol was unaccounted and/or had been taken to excess. Between the 16th and 22nd February 118 out of a 124 repeat prescription Co-Codamol tablets went unaccounted for. As there was reason to suspect that the deceased had taken Co-Codamol in overdose, staff contacted the GP who recommended immediate hospital admission. The deceased declined and so it was agreed that the GP would attend the following day to carry out a review. In the meantime, staff were asked to monitor the deceased. On balance, he was not monitored any more closely than he would normally have been. A GP reviewed the deceased the following day and prescribed Codeine for pain relief. This was never dispensed as events superseded.

	On the night of the 25-26th February 2018 the deceased's health showed a marked decline. The out of hours GP was not contacted for advice. On the morning of the 26th February the deceased started to shown signs of difficulties with his breathing and seizure-like activity. An emergency ambulance was called and he was conveyed to hospital. On admission, he was hyper-pyrexial, tachycardic and confused. Despite treatment, he continued to deteriorate and died in Hospital later the same day. Following post mortem examination and antemortem blood sample toxicological analysis, there was no evidence to suggest that the deceased died as a result of a drugs overdose. The cause of death, on the balance of probabilities, was natural. The medical cause of death was: 1a) Acute left ventricular heart failure 1b) Severe ischaemic heart disease and left ventricular hypertrophy 1c) – 2) -
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:- **Persona and Bury MBC:** 1. Communication/transfer of care/handover between social services, the first placement and/or the final placement was insufficient, given the complexities of the deceased's case. **Persona Only:** 2. The process of assessment of care needs prior to admission was inadequate. Assessment is critical in establishing the suitability and safety of a placement – in this case, capable of meeting complex physical and mental health needs of the individual. Assessment of risk, in particular, was inadequate. 3. The evidence indicated that the: i) Medicine Policy &/or ii)Medicine administration training, supervision and audit processes at Persona were inadequate and unsafe (indeed, the audit process was perfunctory). 4. Staff were unable to recognise the deteriorating adult and did not seek medical attention in a timely manner when signs of change became apparent. This potentially puts service users at risk of harm/death. 5. Record keeping was inadequate and in parts, incomplete. Record keeping is vital in keeping service users safe. 6. There is no policy/protocol for the observation/monitoring of service users e.g. when directed to do so by a medical practitioner. Staff are left to interpret for themselves what this means.

6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 the 3rd October 2018. 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:- - The deceased's family - CQC - Bury CCG 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 from. 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	Date: 8th August 2018 Signed: