Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** 1 **Chief Coroner's Office** 2 **CQC** 3 [redacted] **(Weightman's Solicitors)** 4 **Four Seasons Health Care (HEAD OFFICE)**
1	**CORONER** I am Johanna THOMPSON, Assistant Coroner for the coroner area of Sefton, St. Helens and Knowsley
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 12 July 2022 I commenced an investigation into the death of Beryl ELLISON aged 75. The investigation concluded at the end of the inquest on 20 December 2022. The conclusion of the inquest was that: Mrs Ellison was in declining health and was receiving end of life care. She was found deceased at Alexandra Care Home, Park Road, Newton-le-Willows, on 28th June 2022 as a consequence of her underlying poor health in combination with taking an excessive quantity of her prescribed medication.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Ellison had been in hospital and was discharged to the Alexandra Care Home for Palliative Care. A DNAR was in place. She had previously suffered with pneumonia and Septicaemia, and had an amputation of her leg and finger due to blood clots. Her family had been advised that there was nothing further that could have been done for her medically. On the 28th of June 2022, at approximately 1000 hours, Mrs ELLISON had been due her medication around this time. One of the care workers went into her room to give her her medications and check on her, as it was unusual for Mrs ELLISON not to have not pressed the call button for her medications before this time. When the care worker went in, she noticed that Mrs ELLISON was very drowsy and sleepy. As such, she turned the lights on and noticed she was pale. With this, the care assistant has took her observations, which were concerning. Consequently, she informed the registered staff nurse before calling for an ambulance. As the care assistant returned to the office to make her call, the registered staff nurse informed her that Mrs Ellison had already passed away and it was therefore too late. As such, police and Mrs Ellison's GP were called. The GP attended and pronounced time of death at 1352 hours. Mrs Ellison's son stated he had raised a concern to the care home 4-6 weeks ago about medication being left in his mother's room, as she had been observed hiding it under the bed covers. He had been informed that the staff would administer the morphine and

	observe her taking it from then on. Mrs Ellison's son was concerned that there had been no change in the care home practice since his earlier complaint, which may have led to his mother taking an accidental overdose of her medication.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) Mrs Ellison was resident at Alexandra Care Home and was found deceased on 28th June 2022 by staff. Her family expressed concern that she had been left with syringe medication unsupervised by staff and raised concerns about this with the care home both historically and four days prior to her death. A post mortem examination revealed Mrs Ellison to have an excessive concentration of oxycodone in her system which was likely to exceed any acquired tolerance level. The evidence heard at inquest revealed no explanation as to why Mrs Ellison was found to have taken the excessive quantity of oxycodone which contributed to her death. Furthermore, the systems at the care home were stated categorically to be the same as those that were in place prior to Mrs Ellison's death.
6	**ACTION SHOULD BE TAKEN** In my opinion 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, namely by February 28, 2023. 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 [redacted] **– Representing Alexander Care Home** [redacted] **- Family** **Four Seasons Health Care (HEAD OFFICE)** I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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: 03/01/2023**

	 **Johanna THOMPSON** **Assistant Coroner for** **Sefton, St. Helens and Knowsley**