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.** Dorset Council **2.** Dorset Clinical Commissioning Group
1	**CORONER** I am Stephen John Nicholls, Assistant Coroner, for the Coroner Area of Dorset
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 31st August 2021, an investigation was commenced into the death of Derek Larkin, born on the 10th January 1964. The investigation concluded at the end of the Inquest on the 12th January 2023 The Medical Cause of Death was: 1a Fatal intoxication with morphine. 2 Chronic Ischaemic heart disease with Stenosing Atherosclerosis of the Coronary arteries The conclusion of the Inquest recorded Accidental death.
4	**CIRCUMSTANCES OF THE DEATH** Derek Larkin had a known history of misusing his prescription medications. He had been living at home with a care package of support that included live in carers, up until his admission to hospital he had been dealt with by his local GP practice. He was admitted to Royal Bournemouth Hospital, on the 21st January 2021, suffering from Covid and pneumonia, he was successfully treated.

	On the 8th March 2021 he was discharged from hospital, he was not able to return home and went to reside in a care home. Whilst resident there he was dealt with by a different GP practice. He was prescribed medication. Dorset Council Adult Social Care were responsible for him and had drawn up a Care Plan. Derek Larkin wished to return to his home address and made this known to Adult Social Care in a telephone conversation on the 19th April 2021. Dorset Council liaised with the previous care providers the occupational health team, through a brokerage system they located a different care provider and made arrangements for Derek Larkin to return home on the 20th May 2021. Evidence from healthcare professionals at the inquest confirmed that Derek Larkin had capacity. On the 2nd June 2021 Derek Larkin was found deceased at home by a carer. A post mortem examination demonstrated that he had overdosed on his prescription morphine. From the evidence at the inquest, it is clear that Dorset Council Adult Social Care would have benefited from having knowledge of the medications that had been prescribed. It is clear that family members raised concerns with Adult Social Care about Derek Larkin's access to medication. In addition Adult Social Care would have benefited from any further information from the current GP practice together with his regular GP practice to enable them to consider what might be included within his care plan to include where the medication might be stored and whether it was to be administered by care staff or whether Derek Larkin was self-administering his medication.
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows: There is no evidence that the Dorset Council Adult Social Care computer system Mosaic can communicate with the NHS SytemOne. The Adult Social Care team would benefit from having information about the medication being prescribed to a patient, with the patient's consent, and when that medication was last reviewed. Dorset Council Adult Social Care would benefit from information held by a current or former GP practice as to a patient's medication and how to manage any particular concerns raised by health care professionals or family where a patient is able to independently manage his medication.
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, namely by the 16th March 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: (1) (2) (3) (4) Care Quality Commissioner 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** **19h January 2023**	**Signed** S. J. Nicholls **Stephen J Nicholls**