REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive Officer** **East Lancashire Healthcare NHS Trust** **Trust Headquarters** **The Royal Blackburn Hospital** **Haslingden Road** **Blackburn BB2 3HH**
1	**CORONER** I am Michael Singleton, Senior Coroner for the Coroner area of Blackburn, Hyndburn & Ribble Valley.
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 14 November 2013, I commenced an investigation into the death of Barry Joseph Dillon, aged 68. The investigation concluded at the end of the Inquest on the 4th day of March 2014. The conclusion of the Inquest was that Barry Joseph Dillon had died as a consequence of aspiration pneumonia due to dementia; the conclusion being that of natural causes.
4	**CIRCUMSTANCES OF THE DEATH** Barry Dillon had been detained on Ward 19 at Burnley General Hospital, pursuant to Section 6 of the Mental Health Act 1983, and was transferred to the Royal Blackburn Hospital following seizures. Whilst at the Royal Blackburn Hospital he had suffered a number of aspiration pneumonias, finally succumbing on 13 November 2013.
5	**CORONER'S CONCERNS** During the course of the Inquest the evidence revealed matters giving arise to concern. In my opinion there is a risk that further deaths will occur unless action is taken. In the circumstances it is my duty to report to you the **MATTER OF CONCERN** is as follows: - I received evidence from [redacted], a Specialist Speech and Language Therapist, who stated "There are currently insufficient resources to provide a comprehensive SLT service at the Royal Blackburn Hospital. The Royal College of Speech and

	Language Therapists' guidelines recommend a two working day response time to referrals for a swallow assessment. This is not achieved by the SLT service at the Royal Blackburn Hospital and there is a risk assessment in place which is currently on the East Lancashire Hospitals Trust Corporate Risk Register with an accompanying business case identifying the resources required to address the shortfall in provision". Although Mr Dillon had been referred to the Speech and Language Therapy Service on 17 October 2013, no action was taken until 1 November 2013. I believe that whilst there remain insufficient resources to provide the service at the Royal Blackburn Hospital patients will continue to be at risk of the development of aspiration pneumonia which may prove to be fatal.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 2 May 2014. I, the Coroner, may extend this 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 person, namely: [redacted] 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	**5 March 2014** **Signed by: ……** **H M Senior Coroner for Blackburn, Hyndburn & Ribble Valley**