Robin J. Balmain
SENIOR CORONER

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BLACK COUNTRY CORONER'S DISTRICT
(SANDWELL • DUDLEY • WALSALL • WOLVERHAMPTON
Metropolitan Borough Councils)

Date: 10 September 2014 Our Ref: RJB Your Ref:

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO :

Care Quality Commission
City Gate
Gallowgate
Newcastle-upon-Tyne
NE1 4PA

Dear Sirs,

1. **CORONER**

I Robin John Balmain am the Senior Coroner for the Black Country Coroners Jurisdiction

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 4th and 5th September 2014 commenced an investigation into the death of **JAMES DWAYNE CLARKE**. The medical cause of death was recorded as "Asphyxia compounding severe old head injuries" and the conclusion was "Neglect Compounding Accidental Injuries".

4. **CIRCUMSTANCES OF THE DEATH**

On 15th March 2014 Mr. Clarke was riding a motorcycle unsuitable for the road on 15th March 2009. He collided with the rear of another motor cycle, fell off and collided with a car. He was not wearing a crash helmet. He became paraplegic and had a tracheotomy tube. He was discharged home eventually. Carers were employed at home to care for him, particularly at night. Two carers employed at night did not notice that his tracheotomy tube had become blocked resulting in death.

5. **CORONERS CONCERNS**

The **MATTERS OF CONCERN** are as follows :-

My concerns are that two carers having been employed, the expectation was that one would be with James constantly. The written instructions from the care home said ***"Call is to check James throughout the night and carry out tracheotomy care/suction if necessary"***. Whilst there was no further explanation of what ***"throughout the night"*** meant, the evidence I had was that the carers sat in a room on the other side of the corridor to James's bedroom, they were watching television and playing computer games and talking, they did not check him between 1.a.m and 4.a.m. and again did not check him between 4.10 a.m and 6.a.m and only then because his peg feed alarm sounded. He was found dead at that stage. The carers had had theoretical training, but no practical training had been given to them by the care company who employed them. Their employers were Complete Care Services, which is the trading name of C.C.S. Central Limited of West Midlands House, Gypsy Lane, Willenhall, Wolverhampton, West Midlands WV13 2HA and I was told that the company are registered with the Care Quality Commission. I was concerned that the standard of care provided for James was seriously lacking and that if that standard of care was reflected in the care given to others, to whom CC.S. provided services, then there may be a risk to other members of the public.

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 the report, namely by 5th November 2014.

8. COPIES and PUBLICATIONS

I have sent a copy of my report to the Chief Coroner and to the following interested Persons :

(James's Mother)
C.C.S. central Ltd
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.

R.J. Balmain
Senior Coroner