REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. [redacted], Deputy Manager, John Stanley Agency, 58 Station Lane, Hornchurch, RM12 6NB
1	**CORONER** I am Nadia Persaud, senior coroner for the coroner area of Eastern District of Greater London
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. http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On the 1 October 2014 I commenced an investigation into the death of Michael Joseph Lyons. The investigation concluded at the end of the inquest on the 18 February 2015. The conclusion of the inquest was that Mr Lyons died as a result of an accident.
4	**CIRCUMSTANCES OF THE DEATH** Mr Lyons suffered from Parkinson's disease which developed to Parkinsons, plus PSP in early 2014. He had significant difficulties with balance, speech and swallowing. It is understood that care was provided to him by John Stanley agency carers from around April 2014. Care was initially provided morning and evening, but in September 2014, this was extended to include a lunch time visit. When the Agency were first engaged, information was provided to them about Mr Lyons' difficulty with swallowing. Part of the need for carers to attend Mr Lyons was to assist and supervise him with feeding. Mr Lyons had been assessed by a speech and language therapist (SALT) in April and June 2014. The SALT provided recommendations for the management of his swallowing difficulties and these included providing a list of high risk foods and advice that he should be encouraged to eat slowly; he should take small bites and his food should be cut into small pieces before serving. The list of high risk foods included toast. I heard evidence from Mr Lyons sister, [redacted], who confirmed that she had telephoned the John Stanley Agency to confirm that a SALT assessment had taken place. She could not recall whether she gave any detail of the recommendations made by the SALT, during the call. She stated that she left the list of recommendations including the list of foods by the Blue Book. I understand that the Blue Book is the book used by the Agency carers. It would appear from her evidence that some of the carers were aware of the need to cut up Mr Lyons food.

	It is possible that Mr Lyons moved the recommendations and list. I am however satisfied that the Agency were aware of the need to put in place steps to protect Mr Lyons from the risk of choking (i) from the information provided to them at the outset of their involvement and (ii) as a result of the call confirming that a SALT assessment had taken place. Notwithstanding the risk of choking, the care plan for Mr Lyons provided only for thickener to be added to his orange juice. There was no provision for supervision during eating or for his food to be cut up. On the 23 September 2014 the carer attended and prepared cheese on toast for Mr Lyons. She did not cut it up into small pieces. She watched him eat a bite and then left him to continue, unsupervised. He choked on the toast and this caused his death.
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows. – (1) The Care Agency were aware of the swallowing difficulties experienced by Mr Lyons and they had been informed of a SALT assessment having taken place in June 2014. (2) There was no evidence that the Care Agency had made any attempt to determine the outcome of the SALT assessment and to put into place steps to protect Mr Lyons from the risk of choking. (3) Some carers were aware of the need for food to be cut into small pieces. The carer who attended on the 23 September confirmed that she was not aware that food needed to be cut up. (4) The care plan did not provide a management plan to protect Mr Lyons from the risk of choking. The care plan did not specify that food should be cut up and did not confirm that Mr Lyons should be supervised. (5) The care plan was dated 10 September 2014. The information from the SALT was available at that time and the author of the care plan should have taken steps to ensure that the care plan reflected the recommendations from the assessment.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 3 April 2015. 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] I am also forwarding a copy of the report to the Care Quality Commission and [redacted] (Director of Public Health). 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	**[DATE]** 20-2-15 **[SIGNED BY CORONER]**