	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Care Quality Commission** 2. **Cornwall & Isles of Scilly Safeguarding Adults Board**
1	**CORONER** I am Dr Elizabeth Emma Carlyon, Senior Coroner for the coroner area of Cornwall
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** Mr Norman Henry Charles Dorn died on the 26th August 2014. An investigation was opened on the 2nd September 2014 and was concluded by way of an inquest on the 3rd March 2015. The causes of death were 1(a) Asphyxiation 1(b) Complete Obstruction Of Trachea By Food Particles and in part II Gastric Mucosal Tear With Severe Bleeding. An open verdict was returned.
4	**CIRCUMSTANCES OF THE DEATH** Norman Dorn was found and was presumed to be dead in an armchair at Porte Rouge Residential Home, Vicarage Road, Torpoint at around 11:30 on 26th August 2014 with a sandwich in his hand and with excess food in his mouth. He was last seen alive 10 to 15 minutes before eating a jam sandwich and drinking apple juice. He was known to have swallowing problems and had been provided with soft food. There were no staff trained to recognise death and they did not make attempts to remove the food from his mouth or resuscitate him as required by the care home policy. Nor did the GP attend in a timely manner when requested or staff from other emergency services. It was not clear whether such actions could have resuscitated him or not.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: – 1. That some care homes in Cornwall may not have adequate policies in place for their residence to appropriately recognise or arrange confirmation of death (i.e. when to call Emergency Service and or GP to recognise death). If such policies are in place that they are regularly updated and the staff are made aware of them and given the appropriate training. 2. That some care home in Cornwall my not have an appropriate resuscitation policy in place to ensure that all attempts have been made to preserve life (when appropriate). If such policies are in place that they are regularly updated and staff are made aware of them and given the appropriate training.

6	**ACTION SHOULD BE TAKEN** To review the facts and circumstances of this inquest (disclosure of the statements and reports can be provided) with a view to reinforcing the need to have clear and adequate policies in place to recognise death and carry out appropriate resuscitation or call professional medical help in a timely fashion. In this case the police considered a possible manslaughter charge against the care home staff.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by Monday 4 March 2016. 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 next of kin of the deceased. 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	**08 January 2016** **Dr E Carlyon:** Elizabeth Emma Carlyon