REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: Mr James Thorburn-Muirhead, Chief Executive Officer, Comfort Call Ltd., 2nd Floor, Olympic House, 3 Olympic Way, Wembley, Middlesex, HA9 0NP.

CORONER

I am Chris Morris, Area Coroner for Manchester South.

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/ukpga/2009/25/schedule/5/paragraph/7
http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST

On 4th July 2017, Alison Mutch OBE, Senior Coroner for Manchester South, opened an inquest into the death of Doreen Wilkins who was aged 78 when she died in hospital. The investigation concluded at the end of the inquest which I heard on 10th November 2017.

The conclusion of the inquest was that Mrs Wilkins died as a consequence of a choking incident at home, following a routine care visit which did not last for its full duration. The evidence heard at the inquest did not establish whether or not Mrs Wilkins's death would have been avoided had the care visit lasted for its intended duration. At the end of the inquest, I recorded a Narrative Conclusion to this effect.

CIRCUMSTANCES OF THE DEATH

Mrs Wilkins had been in receipt of a home care package provided by Comfort Care and commissioned by Tameside Metropolitan Borough Council since 2014. In summary, the care package consisted of 4 daily visits by a carer to provide assistance with personal care, monitoring of medication use and food and fluid intake, and encouragement with eating and drinking. Whilst these visits originally were each intended to last for 15 minutes, Mrs Wilkins's care package was increased so as to include 30 minute care visits at breakfast, lunch, and teatime, with a 15 minute evening attendance.

The evidence before the court was that whilst concerns subsisted about the adequacy of Mrs Wilkins's calorific intake, there were no previous documented problems with her ability to swallow food safely.

On 23rd June 2017, the teatime visit was undertaken by the Comfort Call carer who habitually visited Mrs Wilkins at that point in the day. The carer prepared food for Mrs

Wilkins, but did not remain with her for the full 30 minutes duration of the care visit commissioned for her. According to her evidence, the carer stayed for around 20 minutes.

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.

In the course of the inquest I heard evidence to the effect that Comfort Call carers' visits are scheduled in blocks via rotas which do not always allow for travel time between scheduled visits. The matters of concern arising from this are as follows:

1. An absence of any travel time allowance in such circumstances may cause a carer to arrive late for a time critical care visit (such as one where a client is to be supported with regular medication); or
2. A carer may cut short his / her visit to one client to enable them to arrive to their next scheduled appointment on time;
3. In circumstances where a carer is cutting short a visit, the client in question does not receive the duration of care they have been assessed as requiring (or indeed which Comfort Call Ltd has been paid to provide).

It is observed that Comfort Call Limited's registration with the Care Quality Commission is contingent *inter alia* upon a requirement that the registered person must submit on the first day of every month to CQC a report showing:

> *"The actions that have been taken to ensure staff rotas are meeting the needs of service users including time critical calls and travel time between visits".*

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 11th January 2018. 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.

COPIES and PUBLICATION

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

1. [redacted] daughter of Mrs Wilkins.

I have also sent it to Tameside Metropolitan Borough Council, and the Care Quality Commission who may find it of interest.

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.

16/11/2017

Signature 

Chris Morris HM Area Coroner **Manchester South**