REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Care Quality Commission (CQC), Minister of State for Care
1	CORONER I am Alison Mutch, Senior Coroner, for the Coroner area of South Manchester
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 25th August 2016 I commenced an investigation into the death of Jane Olive Parker. The investigation concluded on the 28th June 2018 and the conclusion was one of **Short Narrative** - Died from the recognised complications of aspiration of food contributed to by neglect. The medical cause of death was 1a) Asphyxiation; 1b) Aspiration of Food Stuff; 1c) Vascular Dementia
4	Jane Olive Parker had dementia and a history of choking episodes. Following a choking incident in September 2015, it was indicated by the General Practitioner and the Speech and Language Team (SALT) that she be placed on a stage 3 diet. The Care Home records indicated she was on a stage 4 diet. On 12th July 2016, Jane Olive Parker moved from Millbrook Care Home to Fir Trees Care Home. The existing care plan was used and Jane Olive Parker continued to be recorded as requiring a stage 4 diet. Further difficulties with swallow were not escalated by the care home to the SALT team as a result it was not picked up that she should be on a stage 3 diet and she was not further assessed. On 24th August 2016 Jane Olive Parker was given a non-stage 4 meal which she ate unobserved in her room. Approximately 40 minutes after she was given her meal she was found unresponsive in her room. The pathologist at post-mortem found large pieces of un-chewed food stuffs in the larynx with smaller food particles extending throughout the trachea

	and into the main bronchus.
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. – The inquest heard that: 1. There was poor understanding by the care home assistants of what was meant by the types of modified diets that could be recommended by the SALT teams. Following Mrs Parker's death both the Local Authority in question and the Care Home provider had taken steps to improve knowledge within their care homes but it was unclear if there were national programmes to ensure that care assistants understood modified diets and the importance of adherence to them; 2. Within the care home the system for preparing the correct diets types was such that food would come up to be served and would then need to be put into the correct format by the care staff. There was no regular system of the kitchen sorting and marking food to be served for individual residents with specific dietary requirements such as Mrs Parker. Following Mrs Parker's death both the Local Authority in question and the Care Home provider had taken steps to improve systems within their care homes but it was unclear if there was national work in place to ensure care homes and their kitchens ensured clearly marked food was provided for residents with modified diets; 3. In Mrs Parker's case the Inquest heard that there were opportunities to escalate her case back to SALT after choking episodes. However there was limited understanding within the care home assistants of the need to report and escalate choking episodes to ensure that the SALT team provided expert input and reduced risk. Following Mrs Parker's death both the Local Authority in question and the Care Home provider had taken steps to improve systems within their care homes but it was unclear if there was national work to ensure that there were appropriate systems in place to ensure that there were appropriate escalations to SALT.
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 19th September 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.
8	COPIES and PUBLICATION I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely [redacted], son of the deceased, who may find it useful or 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.
9	**Alison Mutch OBE** **HM Senior Coroner** **25.07.2018**