Berkshire Coroner's Office
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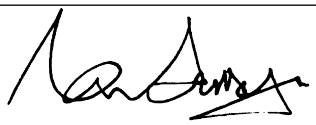
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. NHS Professionals, NHS Professionals Ltd. 3rd Floor Edward Hyde Building, 38 Clarendon Road, Watford, W17 1JW** **2. Prospect Park Hospital, Honey End Ln, Tilehurst, Reading RG30 4EJ**
1	**CORONER** I am Ravi Sidhu Assistant Coroner, for the coroner area of Berkshire
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 3rd October 2017 I commenced an investigation into the death of Anne Roberts 68 years. The investigation concluded at the end of the inquest on 14th September 2018. The conclusion of the inquest was that the medical cause of death was found to be 1a. Choking and the contents of the attached narrative.
4	**CIRCUMSTANCES OF THE DEATH** On the 28th of September 2017, Mrs. Roberts died at Prospect Park Hospital, Reading, having choked on a bolus of food consisting a sandwich and chocolate brownie cake. Immediately prior to choking on the 28th, she was observed, eating in her bedroom where she usually remained owing to her risk of harming others and herself. She was observed by two bank staff from NHS Professionals eating a sandwich and cake at lunchtime whilst resting on her elbow lying on her mattress. Mrs. Roberts had previously been admitted to hospital on the 22nd of September 2017 in respect of an incident involving choking on food and there had been another choking related incident at Prospect Park Hospital on the 27th of September 2017.

	Neither member of the Bank staff were aware of the incident on the 27th of September 2017 and in respect of the incident on the 22nd, members of staff at Prospect Park Hospital were informed that Mrs. Roberts was to be given soft food. It is clear that advice was taken on the 26th of September by a member of Prospect Park Hospital staff from a speech and language therapist (SALT) regarding addressing Mrs. Roberts' risk of choking following the incident on the 22nd. The advice given was, amongst other things, to place Mrs. Roberts on a soft food diet. Unfortunately, the full detail of this advice which provided guidance as to what constituted a soft food diet, was not reflected in Mrs. Roberts' care plan, nor was it disseminated to staff.
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 could 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. Concerns about the training of Bank Staff in relation to the care of patients at risk of choking, including patients who are mentally ill. 2. Concerns about the dissemination of information relating to risk of choking particularly with respect to ensuring that hospital records are full, accurate, and up to date. 3. Concerns about how risk of choking is managed when patients eat in their bedrooms in conjunction with managing risk of harm to themselves and others at the same time. 4. Training of front-line ward staff (including nurses and healthcare assistants/support workers) around the interaction between mental disorders and choking risks, as distinct from choking risks caused by dysphagia
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 Wednesday 12th December 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. 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	 18 October 2018