Coed Duon Care Home

Halkyn Road, Holywell, Flintshire CH8 7SJ

Tel: 01352 712536: [redacted]

27th July 2019

Our Ref: CR/KS/0306

Mr John Gittins

HM Senior Coroner for North Wales (East & Central)

HM Corner's Office

County Hall

Wynnstay Road

Ruthin,Denbighshire

LL15 1YN

Dear Sir

Re: - Report dated 03 June 2019, from Mr David Pojur, the assistant Coroner for North Wales (East and Central). Regarding the circumstances of the death of Mrs Kathleen Smith, Resident at Coed Duon Nursing Home.

In line with our duty of care, I write in response to the above report.

Could I at the outset, again extend my sincere condolences to Mrs Smiths Family from all the staff at Coed Duon.

The death of any resident in our care is distressing for all those involved. Sadly however, they are sometimes what we must unavoidably witness. Nevertheless, notwithstanding this tragic case, I can assure you that our staff are responsible and caring, as was unanimously confirmed by the resident's family's in response to the questionnaires which we sent out in May this year as part of our quality assurance report for the CIW

As you can imagine, the death of Mrs Smith has affected our staff deeply, especially as your report levels an element of blame against them.

However, I must accept the conclusions of the report and have therefore taken steps to implement changes to mitigate against a repetition of this sad occurrence.

Nevertheless, in defence of my staff, Mrs Smith had been at the home four weeks, during which time the staff had been regularly feeding her satisfactorily. On the day in question Mrs Smith's carer, who incidentally had several years' experience who was feeding her. From your report there appears to be no evidence that the food which she had aspirated had not been prepared to a proper safe consistency. As must have been done satisfactorily with no adverse effects on so many occasions before.

I would respectively suggest that the cause of Mrs Smith's death was not due entirely to one single factor which can be leveled entirely at our door, but as your report concludes it was sadly a combination of things including the fact that she was in early stages of pneumonia, and was suffering from both dementia and asthma (Astma in the report). It was these three factors which combined to contribute to her death

With regards to the specific points in the order you raised them: -

1a. You expressed concerns in your report regarding our lack of adequate first aiders. Since then I have, despite difficulty obtaining vacant slots, several members of staff on first aid courses. This now allows us to have at least one qualified First Aider on duty.

1b. All current staff have now been trained on basic awareness of Dysphagia. Also all new staff members have been booked on next available SALT (IDDS) training day which is on 6/08/19. We also now have 2 Dysphagia champions who have done the training for Dysphagia and who are now fully equipped to carry out to train all our staff.

We have now set up a Diets and fluids consistency file for each resident, which have been graded by the exterior health professionals, this file is held in the kitchen and all the kitchen staff have been trained to be aware of its content. If any changes occur hey are given a copy of these changes and all staff now sign to say they acknowledge if there are any changes to their diets.

2. On the day in question, I must once again stress that two members of staff answered the emergency nurse call bell, one was the duty RGN and the other a senior carer, they did intervene and carer remained with her until she passed away, there was no sign she was in distress.

3. As part of their induction training all new staff members are taught how to deliver safe care in residents with a choking risk. We have also made it very clear to new staff that they are NOT allowed to assist residents at risk of choking until this training has been done.

4. We have an RGN on duty 24 hours a day, 7 days a week, also please refer to point 3.

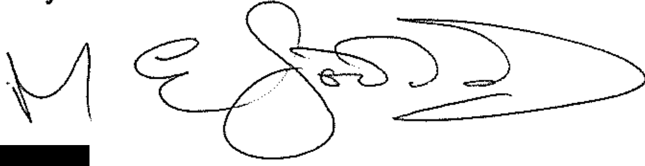
5. There is a trained member of staff on duty in the dining room during mealtimes to oversee the appropriately trained staff in Dysphagia to assist the residents at risk of choking. Also staff now write on diet & fluid charts what daily meals are served and they are clearer on what they have eaten, for example. puree mashed potatoes, puree, instead of Mash, Veg chicken

6. There is always an RGN in the dining room during mealtimes.

I can assure you I take my responsibilities extremely seriously and lessons have been learned, I will endeavour to uphold the highest of standards.

I hope I have covered all the points which you had raised in your report, however, I welcome any constructive thought you may have in the light of these recent events.

Yours faithfully



Proprietor