

Our Ref:

Your Ref:

Regulation 28 REPORT

Date:

11th March 2020

Legal Services Department Manor Hospital Moat Road Walsall West Midlands WS2 9PS

www.walsallhealthcare.nhs.uk

Mrs J Lees Black Country Coroners Court Jack Judge House

Halesowen Street Oldbury West Midlands

B69 3AJ

Tel: 01922 721172 ex Email:

Dear Mrs Lees

Re: Mr Madhavbhai Khusalbhai Patel - Deceased

Date of Death: 13/05/2019

Date of Inquest: 13th January 2020

I am writing in response to your report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. I fully accept that the inquest conclusion of an accident was reached with the potential to identify learning to prevent future deaths.

Website:

I would like to take the opportunity to assure you that as an organisation we have taken this case seriously and have and will continue to ensure actions and lessons from this are enacted and shared widely with staff across the organisation.

Circumstances of the death

On 13/5/19 the deceased choked on an item of food at his home address. He was a 95-year-old gentleman living at home and had his food was prepared by a family member in small bite sized pieces following a swallow assessment. On 13/5/19 his carer attended the address and assisted the deceased with his meal by feeding him small portions of the pre-prepared food. Towards the end of the meal the deceased began to cough and expelled a food item. He then began choking and food was removed from his mouth before he collapsed and was placed on the floor on his side. Emergency services were contacted, Paramedics arrived and removed a food item which was obstructing the deceased's airway. Sadly, despite CPR he was confirmed as having passed away the scene. The deceased had a history of vascular dementia and previous stroke.

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) On the 30/8/18 the deceased had a swallow assessment undertaken at home by the SALT team following a referral by the GP. The recommendations were that a) liquids should be taken in a mildly thick form to slow down the rate of swallow and b) the deceased should follow a soft and bite sized diet. There was no evidence at the inquest that the family had been provided with the

- definition of 'bite sized' in accordance with the International Dysphagia Diet Standardisation Initiative (IDDSI) of 1.5 cm x 1.5 cm.
- (2) The evidence was that the Eating & drinking plan provided to the family following the assessment did not contain the IDDSI definition of 'bite sized'.
- (3) There was no evidence that the family had been provided with a leaflet making reference to the definition of 'bite sized'.
- (4) The evidence was that no specific assessment had been undertaken or advice given with regard to bread or bread products despite the knowledge that the deceased would be following an Indian style diet including bread type products including roti and chapattis in accordance with IDDSI guidelines.
- (5) There was no evidence that advice had been given to the family regarding the deceased's practice of eating with his hands.

The inquest did not find that any of the above matters were causative or contributory to death.

Action Taken

Following the conclusion of the inquest into the death of Mr Madhavbhai Khusalbhai Patel, the Trust has reflected upon the existing policies we follow and advisory documents for patients and their families and recognise that these contain areas for improvement. The Trust has formulated an action plan to address the above identified concerns which include;

- 1. The case and its conclusion have been anonymized and shared across the speech and language team to ensure all colleagues have taken immediate learning from this incident to prevent recurrence.
- 2. The Trust will be seeking to re-establish its nutritional steering group to support and oversee the planning and management for patient nutrition and hydration in the patient's own home and acute hospital settings.
- 3. We will be reviewing and updating our dysphagia policy to fully incorporate the current IDDSI standards to ensure our delivery of care to patients in all settings is undertaken in adherence to these international best practice guidelines by June 2020.
- 4. We will be replacing our current internally developed patient documents with those provided by IDDSI which provide clearer visual guidance to patients and their families / carers about the recommended food and fluid intake as well as the appropriate size of portions and the size of each bite. These documents also include specific reference to "transitional foods", such as breads or similar products such as roti and chapatti, with guidance and an assessment criteria for their consumption. We aim to complete this transition on or before April 1st 2020.
- 5. We will be reviewing and revising our risk assessment and rating document, to specifically include questions about and advice regarding the mode of eating by patients (including the use of hands) to ensure that suitable advice is given to patients who use methods other than forks. This will be achieved as part of the policy review identified above but we endeavor to launch this assessment tool in advance of the ratification of our revised policy. The implementation of these documents will be assured through the completion of a clinical audit 90 days following launch.
- 6. A revised checklist for staff will be implemented to be included within patients records to assure that staff are prompted to handout all relevant supportive and advisory documents to patients and their family / carers and that this can be evidenced. This too will form part of a revised policy but we would anticipate this coming into use prior to the final ratification of the policy to ensure patients are supported.

Finally, may we take this opportunity to offer our unreserved apologies to the family of Mr Patel for distress caused to them during this process along with our sincere condolences for their loss.

Yours sincerely

Richard Beeken Chief Executive

Walsall Healthcare NHS Trust