	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Walsall Healthcare NHS Trust**
1	**CORONER** I am Mrs Joanne Lees, Area Coroner for the coroner area of The Black Country
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 29/5/19 I commenced an investigation into the death of Mr Madhavbhai Khusalbhai Patel. The investigation concluded at the end of the inquest on 13/1/20. The short form conclusion of the inquest was Accident. The medical cause of death was 1a) Acute Upper Airway Obstruction (choking) 1b) Stroke/Dementia 2) Ischaemic Heart Disease/Usual Interstitial Pneumonia (UIP)
4	**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.
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) 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 chapatis 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.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 11/3/20. 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 [redacted] family of the deceased. I have also sent it to the Black Country Partnership NHS Foundation trust and Sandwell & West Birmingham NHS Trust 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	**Mrs Joanne M. Lees** **Area Coroner** **The Black Country Jurisdiction** **14/1/20**