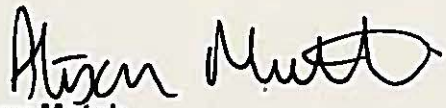
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1) The Care Quality Commission; 2) Meade Close Care Home; 3) Trafford Metropolitan Borough Council; 4) NHS Trafford Clinical Commissioning Group
1	CORONER I am Alison Mutch, Senior Coroner, for the Coroner Area of Greater Manchester South
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 February 2020, I commenced an investigation into the death of Christine Rosemary Neild. The investigation concluded on the 21st September 2020 and the conclusion was one of **Narrative: Died from the complications of a previous surgical procedure.** The medical cause of death was **1a) Sub-acute bowel obstruction; 1b) Incisional hernia including small bowel; II) Tricuspid and mitral valve disease, learning disabilities**
4	CIRCUMSTANCES OF THE DEATH Christine Rosemary Neild had significant learning difficulties. She resided at Meade Close and was funded for a support package including 10 hours of one-to-one care. She previously underwent a surgical procedure and subsequently developed an incisional hernia. She had dysphagia and required puréed food and to be fed. An incident where she placed a non-food item in her mouth was not risk assessed and not escalated. She had a history of getting up in the night but could not always be supervised immediately. On 31st January 2020 at about 9pm, she became very unwell, deteriorated rapidly and died at Meade Close. Post mortem examination found a plastic glove in her stomach. On the balance of probabilities, it did not contribute to her death. She had died from a sub-acute bowel obstruction caused by the hernia linked to previous surgery.

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. – 1. During the course of the inquest evidence was heard that gloves were in open and easily accessible locations throughout the home including in rooms and the kitchen area. The inquest was told that this is standard practice in care settings for people with learning disabilities even where residents do not have insight into what items can safely be placed in their mouths. 2. There had been an earlier incident when Christine Neild had put non-food items in her mouth. The carer did not escalate this and there was no further risk assessment. 3. The inquest heard that in care settings such as this one for those with learning disabilities there was no regular use of sensors to alert night staff of a resident getting up and wandering. Staff relied on hearing a resident getting up despite this being difficult if they were delivering personal care to another resident.
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 27th November 2020. 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 Carol Bradbury, sister 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** **HM Senior Coroner** **02.10.2020**