REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **This report is being sent to:** **Chief Executive** **Sheffield Teaching Hospitals NHS Foundation Trust** **Northern General Hospital** **Herries Road** **Sheffield** **S5 7AU**
1	**CORONER** Abigail Combes
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** In April 2019 I commenced an investigation into the death of Joan Howard. The investigation concluded following an inquest on 4 February 2020 where the conclusion was: • Narrative Conclusion On 10 April 2019 Joan Howard choked on a sandwich provided to her at hospital. The sandwich should not have been provided to Joan and was contrary to appropriate professional advice. Joan's death was therefore contributed to by neglect
4	**CIRCUMSTANCES OF THE DEATH** Joan Howard was admitted to the Northern General Hospital on 4 April 2019. She had a previous medical history of oral cancer and as a result had difficulties with communication and with eating and drinking. She had repeatedly been assessed by the speech and language therapy team and was assessed as requiring level 2 fluid and level 6 food. She had previously been a patient at the Royal Hallamshire Hospital and was given appropriate diet and had been discharged to a care home who had been cognisant of her dietary requirements. Upon admission the Northern General Hospital for unexplained seizures, her dietary requirements were not appropriately managed resulting in her choking to death on a sandwich which should not have been given to her. This was at least the third occasion when a food item which should not have been provided to Joan had been.

	Joan was at the end of her life upon admission to the Northern General Hospital however it is acknowledged by the team investigating her death that she is not likely to have died how and when she died but for the inappropriate provision of a sandwich.
5	**CORONER'S CONCERN** During the course of the investigation my inquiries revealed matters giving rise to a 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 – a) The SALT input into Joan's care was exemplary. She had appropriate assessments and following a visit on the ward the day after her admission appropriate clear posters were placed above Joan's bed confirming what nutrition she could have. Despite these posters, on two occasions Joan was provided with inappropriate food. b) The care home from which Joan was admitted had provided appropriate advice about her nutritional requirements which was available to the hospital upon admission but which was not acted upon. c) The Senior Sister on the ward gave evidence which confirmed that there are processes in place for the management of specialist nutritional requirements on the ward however in this case these were not appropriately followed by staff. d) The Senior Sister on the ward confirmed that she would expect her staff to follow the guidelines issued by the speech and language therapy team and to understand what was meant by level 2 fluids and level 6 food. This was not the case in practice. e) The Senior Sister on the ward confirmed that where someone had capacity and made an unwise choice which contradicted the indication from speech and language therapy, she would expect staff to escalate this to the clinical team to have a discussion with the patient. This was confirmed by the Matron responsible for the presentation of the Serious Incident Investigation at Court however in Joan's case, if staff were aware that the choice of two sandwiches and a piece of cake were inappropriate for Joan, they did not escalate this to the clinical team. f) Joan was sent to an outpatient appointment with no thickener for fluids meaning that prior to her deterioration on the 9 April 2019 she had no access to fluids for the duration of her outpatient appointment and waiting. g) Temporary posters for Joan's nutritional needs were placed above Joan's bed by staff once they became aware of the need for Joan to have a special diet. This was over 12 hours after her admission to the ward and therefore covered an evening meal, breakfast and lunch, during which inappropriate diet could have been given to Joan and definitely was at lunch time. This was despite information being available to the Ward from the care home Joan had been brought in from about her nutritional requirements. Additionally, the Royal Hallamshire Hospital where she had been discharged from earlier the same day before admission to the Northern General Hospital, had information about her nutritional requirements. It wasn't until the family noticed that Joan had been given a sandwich at lunch time on 5 April 2019 that staff placed temporary posters above

	her bed. h) I found that on the basis of the evidence I heard at inquest, neglect had played a significant contributory part in Joan's death as a result of the issues described above. I found that this was largely a cultural and communication issues, particularly once appropriate signage was placed above Joan's bed and errors were still made on at least two further occasions.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, the named organisation have the power to take such action. I am aware of the action plan which the Trust have developed and I praise the frankness with which Matron [redacted] delivered the findings of that report. I however am concerned about a number of areas in the action plan and the Standard Operating Procedure and therefore am requesting you take steps to address these concerns. • Training – I heard in the inquest that the Training and eLearning on International Dysphagia Diet Standardisation Initiative descriptors for special diets would be at the discretion of Care Groups for consideration. There are new descriptors being launched formally in the clinical areas of the Trust. My view is that this is not sufficient and that there should be a Trust requirement for the Training and eLearning to be implemented. The issue in Joan's case was not that there were not processes and policies in place, rather that there was a cultural issue in the Trust which meant that these were not followed. All staff need to be aware of the important of the IDDSM and therefore Training should be Trust wide not based on Care Group discretion. • The Standard Operating Procedure for Ward Meal Services, whilst a promising start requires guidance on what the safety pause is. It is this safety pause which will ensure safe provision of food on a ward provided all Senior ward staff are having the same conversations, using the safety pause in the same way and communicating the same things. • The Standard Operating Procedure also makes reference to when a patient misses a meal they should be offered a snack box. This needs to be amended so that the snack box takes account of special dietary requirements. • The Standard Operating Procedure refers to fluids and fruit juice being available to all patients during meal times; again, there is no reference to specialist advice on patient fluid intake. • Finally, there remains no reference to the fact that there was a period of just over 12 hours where Joan's dietary needs were not made available to ward staff regardless of the Royal Hallamshire where she was discharged from the same day being aware and the care home she was admitted from sending this information into hospital with her. Thoughts need to be given as to how information when it is available, is utilised as soon as someone is in hospital. There also does not seem to have been discussion with Joan (who had capacity notwithstanding her communication difficulties) and her family who were heavily involved in her care. Both of these would potentially have been good sources of information regarding Joan's requirements.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 7 April 2020. I may extend this period upon request.

	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 family. 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	**10th February 2020** **Abigail Combes**