Mid Kent and Medway Coroners
Cantium House
2nd Floor
Maidstone
Kent
ME14 1XD

[redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

Catherine Jux (died 05.04.2021)

	THIS REPORT IS BEING SENT TO: Chief Executive Officer of Avery Healthcare (Elvy Court Nursing Home, 200 London Road, Sittingbourne, Kent)
1.	**CORONER** I am Bina Patel, Area Coroner for the coroner area of Mid Kent & Medway.
2.	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3.	**INVESTIGATION and INQUEST** On 9th April 2021 I commenced an investigation into the death of Catherine Jux who died, aged 86, on 5th April 2021 in an ambulance at Hoath Way Gillingham on the way to Medway Maritime Hospital, Windmill Road, Gillingham, Kent ME7 5NY. The investigation concluded at the end of an inquest on 18th May 2021, conducted by me. I concluded that the deceased had died as a result of misadventure and that the medical cause of death was:

	Ia. Choking and Aspiration of Food into Airways Ib. Ischaemic Heart Disease, Chronic Obstructive Pulmonary Disease, Asthma, Cardiovascular Disease Ic. II.
4.	**CIRCUMSTANCES OF THE DEATH** Catherine Jux died on the 5th April 2021 whilst being transported to hospital by ambulance at Hoath Way in Gillingham. She died as a result of choking and aspiration of food into airways suffered when she choked on food at the Elvy Court Nursing Home on the 5th April 2021.
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: Evidence was given by Nursing Home manager and Nursing staff at the Elvy Court Nursing Home that: (1) Due to an oversight by the home a risk assessment was not completed within 24 hours of the patient being admitted to the home. (2) None of the Care Home staff who attended to the patient and who would refer to this risk assessment to assess a patient's daily needs and requirements noticed the oversight in respect of this. (3) There is not an adequate process in place for auditing that assessments have been completed particularly given the homes policy that they are completed within 24 hours of admission.
6.	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you and/or 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 **28th July 2021**. 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 following: • HHJ Thomas Teague QC, the Chief Coroner of England & Wales • [redacted] on behalf of the family of Catherine Jux • Elvy Court Nursing Home, 200 London Road, Sittingbourne, Kent I am 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.	Signature:  Bina Patel, Area Coroner, Mid Kent & Medway 2nd June 2021