IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Henry Edward Hullin Doll
A Regulation 28 Report – Action to Prevent Future Deaths

1	**THIS REPORT IS BEING SENT TO:** [redacted] Chief Executive The Avenues Trust Group River House 1 Maidstone Road Sidcup Kent DA14 5TA
2	**CORONER** Miss Anna Crawford, HM Assistant Coroner for Surrey
3	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
4	**INQUEST** An inquest into the death of Mr Doll was opened on 7 April 2021. The inquest was resumed on 18 October 2021 and concluded on 19 October 2021. The medical cause of Mr Doll's death was: Ia. Aspiration Pneumonia 1b. Choking and Aspirating on a biscuit (21.2.21) II Dysphasia, Learning, Disability, Dementia, Down's Syndrome

	The inquest concluded that Mr Doll's death was due to an accident, contributed to by failures on the part of his residential care home.
5	**CIRCUMSTANCES OF THE DEATH** Mr Doll had a Learning Disability, Down's Syndrome and Dementia. He was non-verbal and did not have any insight into his own care needs. He lacked mental capacity and was subject to a Deprivation of Liberty Order. His care was funded by West Sussex County Council. Mr Doll lived at Kenilworth, which is a residential care home for up to six people with autism or learning disabilities, which is owned and run by the Avenues Group. Residents at Kenilworth have free access to the kitchen. Mr Doll had been assessed by the Speech and Language Therapy Team (SALT) as being at high risk of aspiration and choking. This was due to a number of factors, namely that he had dysphagia, in combination with a lack of teeth, and the fact that he did not chew his food before swallowing it. Accordingly, the SALT team made a number of recommendations on 20 December 2019, which included that Mr Doll should avoid dry foods and must always be supervised whilst eating. On 21 February 2021 Mr Doll entered the kitchen at Kenilworth alone and got a shortbread biscuit from the biscuit tin. He choked and aspirated on it, resulting in his death from Aspiration Pneumonia the following day on 22 February 2021 at East Surrey Hospital. The court found that those managing Kenilworth had failed to identify the risk of Mr Doll obtaining unsuitable food items from the kitchen and eating them in an unsupervised manner and had also failed to put in place appropriate measures to prevent him from doing so.

6	**CORONER'S CONCERNS** **Risk assessments** The court heard evidence that a formal written risk screening tool was completed in relation to the risk of Mr Doll choking on 20.10.20. The risk was scored as '6' meaning that the risk of him choking was considered to be possible and that if he were to choke the likely impact on him would be low. This score placed him in the yellow band of risk according to the risk assessment matrix, meaning that the risks could be sufficiently mitigated with use of 'positive behaviours support' or small adjustments to activity. Both the Kenilworth Home Manager and the Regional Director, who is responsible for some 50 homes within the Avenues Group, gave evidence at the inquest that Mr Doll's risk screening had been correctly completed and that the process for completing the risk screening was to first consider what mitigating measures were already in place and then to assess the likelihood of the risk occurring and the likely impact on the individual. The court found that both witnesses had misunderstood the risk assessment process and that the risk screening completed in respect of Mr Doll was completely at odds with the SALT assessment and had been inaccurately completed. Had it been accurately completed Mr Doll would have received a higher score placing him in the red band of risk according to the risk assessment matrix, requiring the risk to be reported to a senior manager to sign off on the care plan and requiring Mr Doll to be placed on the Avenues Group risk register. The Court found that had this process been followed it was likely that the risk posed to Mr Doll by way of free access to the kitchen would have been identified and mitigated prior to his death. **First aid** The court found that the Cardio-Pulmonary Resuscitation (CPR) provided by care staff prior to the arrival of the paramedics on 21 February 2021 was not effective, albeit this did not contribute to Mr Doll's death.

	The **MATTER OF CONCERN** is: 1. Both the Kenilworth Home Manager and the Regional Director, responsible for some 50 homes, maintained at the inquest that Mr Doll's risk assessment had been accurately completed and that the appropriate way to conduct a risk assessment was to first consider what mitigating measures were in place and then to go on to assess the likelihood of the risk occurring and the likely impact on the individual. Accordingly, the Coroner is concerned that the risk screening in respect of other residents at Kenilworth, but also other Avenues Group locations, may have been completed in a similar manner. The Avenues Group is invited to consider carrying out an audit of the current risk assessments in place and to ensure that all those involved in the auditing process have a clear understanding of the process. The Avenues Group is also invited to consider whether further training is required in relation to the completion of the risk screening tool. 2. The court found that the CPR provided by staff to Mr Doll on 21 February 2021 prior to the arrival of the paramedics was ineffective, albeit this did not contribute to his death. The Avenues Groups is invited to consider whether staff have received sufficient practical training so as to ensure that they are confident and capable of carrying out effective CPR.
7	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.

8	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
9	**COPIES** I have sent a copy of this report to the following: 1. Chief Coroner 2. Mr Doll's family 3. West Sussex County Council 4. Care Quality Commission
10	**Signed: ANNA CRAWFORD** **Anna Crawford** **H.M Assistant Coroner for Surrey** **Dated this 20th day of October 2021**