Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1. Executive Director Adult Social Care & Health, Derbyshire County Council, County Hall, Smedley Street, Matlock, Derbyshire, DE4 3AG** **2. Chief Executive, NHS Derby & Derbyshire Clinical Commissioning Group, Cardinal Square, 1st Floor, North Point, 10 Nottingham Road, Derby, DE1 3QT**
1	**CORONER** I am Peter NIETO, Area Coroner for the coroner area of Derby and Derbyshire
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 30 December 2020 I commenced an investigation into the death of Mark Edwin SUMNALL aged 64. The investigation concluded at the end of the inquest on 14 April 2022. The conclusion of the inquest was that: Mark Sumnall, known as Mark, died in hospital, on the morning of 21 December 2020, due to choking and aspirating on a sandwich given to him by hospital staff. Mark had been taken to the hospital by ambulance the previous afternoon as he appeared physically unwell and was acting out of character. Mark was diagnosed with chronic schizophrenia, and chorea movement disorder. He had a recognised choking risk due to rushing his food and his food had to be appropriately cut up and Mark was supervised whilst eating. When Mark was taken to hospital by ambulance on 20 December 2020 the care home sent Mark's medication and care plan, which contained details of the choking risk, with him in a 'red bag'. The 'red bag' is a specific bag, of a holdall size, issued under a countywide scheme to highlight and transfer key documents relating to health and care when people are taken from community settings to hospital. On the evidence the hospital staff were not aware of Mark's choking risk, despite his care plan being with him in the 'red bag' at the hospital. On the evidence Mark would not have died if hospital staff had been aware of that risk because he would have been given appropriate food under supervision. The hospital staff were not aware because: - 1. The presence of the 'red bag' was not highlighted to hospital staff by the member of the ambulance service who handed mark over. 2. Choking risk was not recorded on the emergency department handover record when Mark was handed over by the ambulance staff. 3. The contents of the 'red bag' was not investigated by hospital staff prior to Mark's death. 4. A telephone conversation between an emergency department doctor and a member of

	the care home staff did not explore Mark's needs and risks. 5. The ambulance service patient attendance document was not reviewed by hospital staff. 6. The hospital electronic data systems at the time did not permit the hospital staff to access Mark's previous hospital records which contained information of his choking risk.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances are detailed above in section 3 of this report. The medical cause of death, confirmed at inquest, was: - 1(a) Food inhalation 2 Schizophrenia, coronary atherosclerosis
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: The Derbyshire wide Red Bag scheme is an initiative designed to ensure that when care home residents are admitted to hospital, key health and social care information travels with them by way of documentation such as care plans (as well as medication and essential personal items). I understand that the County Council and the CCG are the primary agencies responsible for the scheme. On the evidence considered at Mr Sumnall's inquest: - 1. The scheme does not appear to be widely used in Derbyshire, although the scheme was in response to NICE guidance for improving patient care and safety when transferring between health and care settings (NG27: Transition between inpatient hospital setting and community or care homes). The inquest heard that Mr Sumnall's care home only had one bag for use on the premises, and that ambulance and hospital staff did not routinely deal with admissions where care home patients were sent with Red Bags. 2. The Red Bag travelled with Mr Sumnall and was found with his clothes when he died. Despite being with him there is no evidence that anyone looked in the bag to check for relevant information. This being the case it appears to me that there is lack of awareness of how the bag should be used, but also, as no enquires were separately made for care plan and other relevant documentation, that the thrust of the NICE guidance for improving patient care and safety is not being addressed systematically between agencies.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 July 21, 2022. 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 - Mr Sumnall's family - Royal Derby Hospital - Aspen House Care Home I have also sent it to - East Midlands Ambulance Service who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	**Dated: 30/05/2022**  **Peter NIETO** **Area Coroner for** **Derby and Derbyshire**