REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] - Registered Manager Hibiscus House** **2. [redacted] - Nominated Individual/Chief Officer Hibiscus Housing Association Ltd** **3. The Quality Care Commission (CQC)** **4. Wolverhampton City Council** **5. Health and Safety Executive**
1	**CORONER** I am Mrs Joanne Lees Area coronerfor the coroner area of The Black Country.
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. https://www.legislation.gov.uk/ukpga/2009/25/schedule/5 https://www.legislation.gov.uk/uksi/2013/1629/part/7
3	**INVESTIGATION and INQUEST** On 8/6/22 I commenced an investigation into the death of Charles Evans aged 66. The investigation concluded at the end of the inquest on 23/8/22. The medical cause of Mr Evans death was; 1a) hypoxic brain injury 1b) out of hospital cardiac arrest 1c) aspiration of food 2) drug-induced Parkinson's disease The conclusion of the inquest was Accident.
4	**CIRCUMSTANCES OF THE DEATH** Mr Evans suffered with Parkinson's disease. He was a resident at Hibiscus House, Wolverhampton which was supported/sheltered accommodation providing personal care to residents. On 29th May 2022 whilst in the communal dining room Mr Evans was found choking on his lunch which consisted of mashed potato, cabbage and roast beef. He collapsed at the table. The emergency services were called and staff commenced CPR on the instructions of the 999 call operator. On arrival of paramedics Mr Evans was in cardiac arrest. Paramedic removed a large chunk of mash potato from his airway. He was resuscitated and taken to New Cross Hospital. He suffered 2 further cardiac arrests. A CT scan revealed a global hypoxic brain injury and Herniation of part of the Brain Stem. Mr Evans proceeded to go into Multi-Organ Failure including Respiratory Failure, Cardiac Failure and Renal Failure. It was deemed that Mr Evans prognosis was low and a discussion with family followed, a decision was made to palliate Mr Evans and make him comfortable. Mr Evans passed away at New Cross Hospital 30th May 2022. Mr Evans had no known dietary requirements or issues with his swallow.
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 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. – During the course of the inquest I heard evidence from Faye Cadogan Registered Manager Hibiscus House and Norma Chambers Catering Assistant at Hibiscus House. 1. None of the Carers employed at Hibiscus House had any training in CPR. The carer on duty was qualified to Level 2 Diploma in Health & Social care which does not include any training in first aid; 2. At the time of the incident there were no staff members trained in CPR (Coroner was told this had been rectified post Mr Evans death); 3. There was no Registered First Aider at the premises; 4. There was no defibrillator on site; 5. There was no requirement for any staff to be on duty in the communal dining room during mealtimes despite the fact the Hibiscus House could cater for residents with special dietary requirements; 6. There was no emergency bell/alarm or telephone in the residents' dining room. Staff were expected to use their mobile phone to call for help; 7. There was no procedure for what should happen in an emergency situation (in this instance the catering staff member who found Mr Evans located a carer instead of calling 999 themselves; 8. Staff did not know who else was on duty at any given time; 9. There was no proper procedure in place for staff to reports concerns about residents; 10. No further risk assessments were being conducted if a resident returned to Hibiscus House after a hospital admission to ensure the facility could still meet the needs of the resident (Coroner was told staff relied on a discharge summary and/or the GP); 11. Post inquest, the Coroner noted the CQC Inspection report for Hibiscus House Domiciliary Care Agency dated July 2019 which rated the facility as '*requiring improvement'*. The Coroner is concerned to establish whether the service provider put forward an action plan following the CQC Inspection setting out what they would do to improve the standards of quality and safety and whether the CQC monitored any progress towards said plan.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action. The Coroner would invite the Local Authority and CQC to ***urgently*** review/revisit Hibiscus House given the concerns raised and concerns identified regarding training raised in the CQC report referenced above. ** The name of the Registered Manager appears incorrect on the CQC website.*
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **24/10/22**. 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 [redacted] 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 other 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.
9	**25/8/22**