REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Greater Manchester Health and Social Care Partnership**
1	**CORONER** I am Alison Mutch, Senior Coroner, for the Coroner Area of Greater Manchester South
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 16th March 2022 I commenced an investigation into the death of John Fallon. The investigation concluded on the 7th September 2022 and the conclusion was one of **Accidental Death**. The medical cause of death was **1a) Choking on food; 2) Dementia**
4	**CIRCUMSTANCES OF THE DEATH** John Fallon had dementia and was resident at Downshaw Lodge Care Home. On 13th March 2022 he was eating his lunch without his dentures in. He had cut up his own food. He began to choke. Emergency services attended and a large piece of partially chewed meat was retrieved using suction on his airway. He was transferred to Tameside General Hospital where resuscitation attempts were continued. They were unsuccessful. He died at Tameside General Hospital on 13th March 2022.
5	**<u>CORONER'S CONCERNS</u>** 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. – 1. The inquest heard evidence that although he needed his dentures to chew in a satisfactory way, SALT assessments are not routinely carried out where an individual goes from eating with dentures to eating without dentures. As a consequence the diet is not routinely altered in a

	care home setting to reflect the reduced chewing capacity; 2. Evidence was also heard that the limited availability of dental services to care home residents means that situations where dentures require updating/replacing are not being dealt promptly which means there is a greater risk of choking on food that has not been adequately chewed; 3. NWAS used a suction machine to clear the airway on their arrival. The inquest heard evidence that these are not routinely in place at care homes and so if a resident is choking food cannot be suctioned out by staff.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 **30th December 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 namely Mr Fallon's Family and Qualia Care Limited, who may find it useful or of interest. 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	**Alison Mutch OBE** **HM Senior Coroner**  **04.11.2022**