REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

Tina Jane Allen deceased.

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **Chief Executive Officer** **Home Farm Trust Limited (HFT)** **5-6 Brook Office Park Folly Brook Road** **Emersons Green** **Bristol** **BS16 7FL**
1	**CORONER** I am Guy Davies, His Majesty's Assistant Coroner for Cornwall & the Isles of Scilly
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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 15 June 2022 I commenced an investigation into the death of Tina Jane Allen. The investigation concluded at the end of the inquest on 5 December 2022. The conclusion of the inquest was as follows The medical cause of death 1a Aspiration Pneumonia 1b Choking II Neurological Condition Autism The answers to the statutory questions - who, when, where and how – were answered as follows … Tina Jane ALLEN died on 15 June 2022 at Royal Cornwall Hospital Treliske Truro Cornwall from choking on high-risk food against a background of autism being a known risk for choking My narrative conclusion as to the death was Choking contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** Tina was diagnosed with severe autism requiring 24-hour care on a 1:1 basis. Tina lived at Valley View House in Cornwall. Valley View is a Registered Care Home, which is owned and managed by HFT. Tina had eating and drinking guidance in place, assessed by a Speech and Language

	Therapist (SALT) requiring a diet of soft and mashed food and avoiding high risk foods. Tina choked on food given her by carers on 13 June 2022 and was admitted to hospital. She died two days later. On the basis of evidence from the SALT the court found that the foods given on 13 June were high risk could not have been prepared safely. It was found that Tina was fed high risk foods for at least 3 months by carers at the home. There was evidence staff were unaware of the extent of the eating plan. The management at the care home had not completed routine checks which would have revealed this error. There was a requirement for extra vigilance by management following a choking incident in 2020 in which Tina had required CPR and was airlifted to hospital for treatment. On the day of the fatal incident the care home was at least one third understaffed. Staff report ongoing issues of understaffing that impact on the ability to safely provide care and training. Staff have alerted management to these staffing issues on a number of occasions. The court heard that on a majority of days the care home is understaffed.
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. – That the persistent understaffing at the care home is impacting upon the ability of staff to safely provide the care and treatment required. Further, the understaffing is impacting upon the ability of the care home management to properly monitor the safety and appropriateness of the care given at the care home. The care home is invited to review the staffing levels at the home and the relevant recruitment and retention policies and strategy.
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 30 January 2023. 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: Family [redacted] I have also sent it to who may find it useful or of interest.

	[redacted] CQC 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	**5 December 2022** **Guy Davies**