REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: HIGHGROVE REST HOME, BLACKPOOL**
1	**CORONER** I am Andrew Cousins, Assistant Coroner, for the area of Blackpool & Fylde.
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 10 July 2023, at an inquest held at Blackpool Town Hall, I returned a short form conclusion that Mr Terence Burns died as a result of misadventure. I found the cause of death to be: 1 (a) Choking ii Bronchopneumonia and brain infarct
4	**CIRCUMSTANCES OF THE DEATH** I returned the following in box 3 of the Record of Inquest recorded: Mr Terence Burns was resident at the Highgrove Rest Home, Blackpool. The care plan that was put in place for Mr Burns included that he required a blended food diet. On 28 October 2022, Mr Burns' physical condition deteriorated and an ambulance was called to the Highgrove Rest Home. When Mr Burns was transferred to Blackpool Victoria Hospital, his dietary requirements were not notified to North West Ambulance Services. Consequently, during his course of treatment, the dietary requirements for Mr Burns were not known by Blackpool Victoria Hospital. During the evening of 28 October 2022, Mr Burns was given a sandwich to eat at Blackpool Victoria Hospital. At approximately 22.52hrs on 28 October 2022, Mr Burns was found unresponsive in the hospital cubicle with food reside in his throat. Mr Burns displayed no breathing effort and died at approximately 23.00hrs.
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:

	The evidence in this case was that Mr Burns had a history of food aspiration, and following an assessment by the SALT team, he was placed on bended diet. The written care plan that was in place at Highgrove Rest Home did not contain the information that Mr Burns required a blended diet. Having heard the oral evidence from the two carers who attended the inquest to give evidence, I accepted that Mr Burns was being fed a blended diet in advance of his attendance at hospital on 28 October 2022. I found that the monthly reviews of the care plan, that were carried out on 4 September and 8 October 2022, did not amend the care plan to include the need for a blended diet, and accordingly the written care plan did not accurately define the nutritional needs of Mr Burns. This missing information from the care plan was a concern for me as the documentary evidence relating to the nutritional requirements of Mr Burns was not correct. Furthermore, I was concerned that the oral evidence that I heard at the inquest, established that the documents handed over to North West Ambulance Services when Mr Burns was taken to hospital, were not checked. When Mr Burns was taken to hospital, it could not be ascertained what information was sent with Mr Burns to enable the hospital to meet his care needs. I found that these matters gave rise to a risk of further death and engaged my duty under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
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 8 September 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: The family of Terence Burns The Care Quality Commission 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	**Andrew Cousins**  **Assistant Coroner for Blackpool & The Fylde** **Dated: 14 July 2023**