Regulation 28: Prevention of Future Deaths Report

Mr Ronald James JEPSON (died 15th March 2023)

THIS REPORT IS BEING SENT TO:

1. [redacted]
2. [redacted]

1. CORONER

I am: Delroy Henry, Area Coroner, Coventry. Coventry Coroners Office, The Register Office, Manor House Drive, Coventry, CV1 2ND

2. CORONER'S LEGAL POWERS

I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and

The Coroners (Investigations) Regulations 2013, regulations 28 and 29.

3. INVESTIGATION and INQUEST

On 16th March 2023 I commenced an investigation into the death of Mr Ronald James JEPSON (aged 75 years). The investigation concluded at the end the inquest on 19th January 2024 at Coventry Coroners Court. The conclusion of the death of Mr Jepson was that death was "misadventure", a copy of which I attach to this report.

4. CIRCUMSTANCES OF THE DEATH

Ronald James JEPSON had a history of schizophrenia, and resided at Meadow House, a mental healthcare facility. An aspect of Mr Jepson's care plan was supervision when he was provided a meal/eating, Mr Jepson with a known risk of cramming food into his mouth and thereby choking. On 14th March 2023 Mr Jepson was sat in the TV lounge and provided his supper which consisted of some jam sandwiches. It was inconclusive as to whether the jam sandwiches were cut into sufficiently small pieces. Also in the lounge was another resident with the same meal. Mr Jepson, a short time later, his plate cleared from the room, had an unwitnessed choking episode. Care home staff, upon hearing Mr Jepson 'gargling', came to his location in this emergency situation. 111 was called by care home staff, in due course the matter correctly escalated by the call handler to enable an ambulance to be immediately dispatched. First attempts as resuscitation by care staff were following an appreciable period of time and the cardiopulmonary resuscitation was sub optimal. Ronal Jepson had turned blue (cyanosis) and an ambulance arrived. Despite paramedics attempts at resuscitation at Meadow House care home (a return of spontaneous circulation attained) and at UHCW hospital, Mr Jepson died at hospital on 15th March 2023, the cardiac arrest precipitated by the episode of choking on food, (food lodged in the windpipe and thus air prevented from getting to the lungs thereby damaging vital organs and causing the deceased heart to stop).

5. CORONER'S CONCERNS

During the inquest, the evidence and information 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:

i. Timely and commensurate interventions of care staff can have a significant positive bearing upon the outcome of a choking episode. Training on how to deal with emergency situations is not ingrained in care home staff.

ii. The circumstances of this inquest touching upon the death of Ronald JEPSON accentuated this point. The evidence was that Mr Jepson 'gargling' and becoming unresponsive was an emergency. 111 (a non-emergency number) was called by care home staff and not 999.

iii. A call handler recognising it was an emergency escalated matters and guidance was given to care staff as to CPR. First attempts as resuscitation by care staff were following an appreciable period of time (ascribed to inexperience and panic) and the cardiopulmonary resuscitation was sub optimal.

iv. The removal of the food occluding the airway of Mr Jepson and effective CPR was provided by paramedics immediately lead a reduced cyanosis.

v. A choking episode, of itself, is a time critical event.

vi. Such training at the time of the incident was ineffectual and infrequent (online) with the consequence being that when an emergency arose the actions of staff to aid a resident were cumulatively sub optimal.

vii. Following the incident there has been no significant increase in training frequency such as would better enable commensurate training to be ingrained in staff which may make significant difference in averting an adverse outcome for a resident in need of emergency care/ assistance.

6. ACTION SHOULD BE TAKEN

In my opinion, action should be taken to prevent future deaths and I believe that 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 6th May 2024. 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 following:

1. HHJ Thomas Teague KC the Chief Coroner of England & Wales Chief Coroner's Office, 11th Floor Thomas More, Royal Courts of Justice, Strand, London, WC2A 2LL. chiefcoronersoffice@judiciary.gsi.gov.uk
2. Ronald James JEPSON's family.

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.

Date: 11th March 2024