REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: HADDON COURT 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 9 and 10 May 2024, at an inquest held at Blackpool Town Hall, I returned a short form conclusion that Mr Terence Manning died as a result of an accident. I found the cause of death to be: 1(a) Hypoxic brain injury 1(b) Out of hospital cardiac arrest 1(c) Choking on a food bolus II Frontotemporal dementia
4	**CIRCUMSTANCES OF THE DEATH** I returned the following in box 3 of the Record of Inquest recorded: Mr Terence John Manning resided at Haddon Court Rest Home, 8-14 Haddon Road, Blackpool. Mr Manning had become a resident at Haddon Court on 29 June 2023. On 22 October 2023, Mr Manning was eating a meal at the rest home, when he experienced a choking incident. Mr Manning was taken by ambulance to Blackpool Victoria Hospital where, despite receiving treatment he died on 24 October 2023. Mr Manning had been identified to have a propensity to eat quickly, but a Speech and Language Therapy ('SALT') referral had not been made in his case, in circumstances where there was an opportunity for such a referral to have been made. It is not possible to say as to what the conclusion of any SALT referral would have been.
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: Mr Terrence John Manning was a resident at Haddon Court from 29 June 2023. It was known to Haddon Court Rest Home, that Mr Manning had a propensity to eat quickly and to take food from other plates.

	Mr Manning was not being fed a pureed or soft texture diet, and entries to this effect in the care records are errors in the record keeping. These errors had been caused by carers carrying forward the details of records relating to other residents from entries made on the records of those other residents. It was noted in the evidence, that erroneous record keeping had taken place over a period of time and involved multiple carers. It was caused by carers transposing the records of one resident into the care records of another, leading to inaccuracies. I found that these matters gave rise to a risk of further death as the record keeping was inaccurate and did not reflect the foods being given to Mr Manning, 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 5 July 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 Chief Coroner and to the following Interested Persons: The family of Terence Manning The Care Quality Commission Lancashire County Council Blackpool Council 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: 10 May 2024**