ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Caremark (Chiltern & Tree Rivers) 5 Greenway, Chesham HP5 2DA
1	**CORONER** I am Priya Malhotra, assistant coroner, for the coroner area of Berkshire.
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 28 July 2023 an investigation commenced into the death of Sally Mills, aged 85. The investigation concluded at the end of the inquest on 11 October 2024. The conclusion of the inquest was that Sally Mills died as a result of choking on her prescribed medication, which was contributed to by continued administration of medication following signs of difficulties in swallowing against a background of recent difficulties. A forensic post-mortem examination concluded her medical cause of death was consistent with choking.
4	**CIRCUMSTANCES OF THE DEATH** The deceased received carers 4 times a day at her home address, and they assisted her in the administration of her medication. She took 5 tablets in the morning. Following concerns raised by the District Nurse on 18 July 2023, regarding swallowing of tablets, care assistants were advised to keep the deceased at a 90-degree angle when administering medication. This was implemented into her care plan. On 22 July 2023 further difficulties with taking the medication were noted twice that day and not escalated. On 23 July 2023 the deceased's medication was administered with the assistance of a care assistant at home. She was displaying signs of discomfort following the 3rd tablet and then difficulty swallowing the 4th tablet. She choked after taking the 5th tablet becoming unresponsive. Paramedics attended and she was conveyed to Wexham Park Hospital where she passed away the same day at 9.30am.
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 could 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) **First Aid training.** The evidence revealed there is still a lack of understanding of providing first aid to those becoming unresponsive. (2) **Escalation of issues encountered by care assistants being appropriately escalated.** Whilst the evidence demonstrated efforts have been made in this regard, such as a new checklist, and new policy dated September 2023; the evidence revealed lack of knowledge of the policy and embedding of it.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 Monday 9 December. 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 family of Sally Mills. 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	**14 October 2024** **Priya Malhotra**