REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: The Chief Executive Officer, Harbour Healthcare Ltd., Lodge House, Dodge Hill, Stockport, SK4 1RD

CORONER

I am Chris Morris, Area Coroner for Manchester South.

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.
http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7
http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST

On 18th October 2024, I opened an inquest into the death of Susan Paley who died on 11th May 2024 at Hilltop Court Nursing Home, Dodge Hill, Stockport, aged 65 years. The investigation concluded with the inquest which I heard on 22nd November 2024.

A post mortem examination determined Ms Paley died as a consequence of:

1) a) Asphyxia;

1) b) Food bolus obstruction.

At the end of the inquest, I recorded a **conclusion of Accident**.

CIRCUMSTANCES OF THE DEATH

Ms Paley was a resident at Hilltop Court Nursing Home who was significantly dependent on the care of others as a consequence of complex neurological problems which left her with tremors, contractures and very limited mobility. Whilst Ms Paley had previously reported swallowing problems, the outcome of her most recent Speech and Language Therapy Assessment was normal meaning no modification was required to her diet.

On 11th May 2024, a Healthcare Assistant had left Ms Paley with a sandwich to eat in bed in her room. When around an hour later the same staff member returned to check on Ms Paley, she found her unresponsive. Whilst staff sought to assist Ms Paley and an ambulance was called, an attending paramedic confirmed she had died.

Ms Paley died having choked on food whilst eating in her bed.

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.

1. Given Ms Paley's significant health problems and very limited mobility, it is a matter of concern that she had been left in bed without a call bell to hand which she could easily reach should she need to summon assistance; and
2. I am concerned that care staff at Hilltop Court do not currently have a checklist in use to accompany them when checking on residents which would act as an aide-memoire / confirmatory check that residents who require any specific aids (for instance bedrails, call-bell, sensor-mats etc.) have them in place as indicated.

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by **21st January 2025**. 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.

COPIES and PUBLICATION

I have sent a copy of my report to Ms Paley's sister on behalf of her family.

I have also sent a copy to the Care Quality Commission and Stockport Metropolitan Borough Council who may find it useful or of interest.

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.

Dated: **26th November 2024**

Signature: Chris Morris HM Area Coroner, Manchester South.