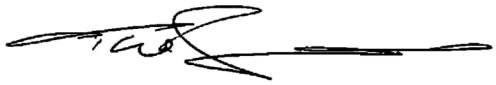
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS THIS **REPORT IS BEING SENT TO:** **1 The Chief Executive, Bolton Cares, Thicketford Road, Bolton. BL2 2LW**
1	**CORONER** I am Timothy William BRENNAND, Senior Coroner for the coroner area of Manchester West
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 30 July 2024 I commenced an investigation into the death of Craig Brendon SPIBY aged 49. The investigation concluded at the end of the inquest on 21 November 2024. The conclusion of the inquest was that: Accident contributed by neglect.
4	**CIRCUMSTANCES OF THE DEATH** The deceased suffered from Phelan McDermid Syndrome - a rare and debilitating chromosomal disorder, that amongst other symptoms, rendered him susceptible to choking on food and liquids at mealtimes. From 2009, the deceased's extensive health care needs were being met actively upon him becoming at full time resident at a locally authority funded assisted living facility at [redacted], Farnworth. On the 13th of July 2024, when eating his lunch whilst unsupervised and only indirectly monitored in the kitchen of the residence, he rapidly became collapsed and unresponsive having inadvertently choked on a sandwich. His condition was not appreciated for a significant period, the duty carer on returning to the kitchen erroneously assumed the deceased had fallen asleep until later realising the deceased was totally unresponsive. Despite prompt attendance and attempted resuscitation by emergency paramedics, he failed to respond and at 12.23pm that day was pronounced dead. A post-mortem established the deceased to have choked on a bolus of masticated sandwich that had lodged in his windpipe that would have caused hypoxic driven cerebral malfunction and potential loss of consciousness within four minutes and irreversible cardio-respiratory failure within 10 minutes.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) The deceased had an enduring risk of choking, especially at mealtimes, and was the subject of a Care and Support Plan; Bad Day Support Plan; Good Day Consistency and bespoke Eating and Drinking Guidelines that had been updated in 2018. The Care and Support plan made clear that at mealtimes in particular, the deceased ought

	to be 'monitored'. The Speech and Language Therapy guidance made clear that at mealtimes the deceased was to be 'supervised'. Managers gave evidence that their definition of 'monitoring' and 'supervising' was an expectation that the deceased would be kept in 'line of sight' at all times. Care workers gave evidence that they were expected only to 'monitor' the deceased – which had the consequence of meaning they felt it appropriate to leave the deceased unsupervised but within earshot, in differing rooms of the care facility for short period of time. Care workers also gave evidence to the effect that improvement to first aid training when dealing with a choking or aspiration emergency would be beneficial. It follows that the following matters of specific concern arise: 1. A lack of understanding and/or training as to the specific requirements and expectations as to the role of care staff when supervising/monitoring a service user. 2. The confusion that arises in the existence differing language that applies in Care Plans and Guidance with no corresponding definition of the terms used. 3. How and why staff having assumed the deceased to have fallen asleep at a mealtime after a period of absence from the room, did not use more professional curiosity to evaluate whether such an assumption was correct or safe. 4. The lack of confidence expressed by staff in the emergency first aid training provided when responding in a choking case. 5. An absence of training to guard against confirmation bias with long term service users who have enduring high risk of choking, but with no actual previously recorded episodes of such events.
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 February 04, 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the family of Craig Spiby. I have also sent it to **Bolton Council** **Care Quality Commission** who may find it useful or of interest. 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 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 by the Chief Coroner.
9	**Dated: 10/12/2024**  **Timothy William BRENNAND Senior Coroner for Manchester West**