ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Ashley Gardens Nursing Home**
1	**CORONER** I am Patricia Harding, senior coroner for the coroner area of Mid Kent and Medway
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 the 3rd December 2013 I commenced an investigation into the death of Keith Barton, 77 years. The investigation concluded at the end of the inquest on the 4th December 2013. The conclusion of the inquest was that Keith Barton died as the result of an accident, the medical cause of death being 1a. Inhalation of food II Dementia. Box 3 was completed that Keith Barton suffered from Alzheimer's disease and dementia. He had a history of pocketing food and not swallowing and was therefore at a risk of choking. He was assessed by a speech and language therapist as requiring supervision and monitoring whilst eating. At the nursing home supervision was by way of periodic check. On the morning of the 5th February 2013 he choked and died whilst eating his breakfast in his room on his own. There is no evidence that he was checked while eating his breakfast
4	**CIRCUMSTANCES OF THE DEATH** Keith Barton had a history of Alzheimers disease and dementia and as a result had a history of pocketing food and not swallowing. He was therefore at risk of choking. Whilst resident at Ashley Gardens nursing home he had been assessed by a speech and language therapist (SALT) as requiring supervision and monitoring while eating. It was not clear whether this was communicated at the time of the assessment but was confirmed in writing at a later date. This was interpreted by staff at the nursing home as intermittent rather than constant supervision and when eating breakfast in his room he was subject to periodic checks. The majority of meals were taken in a communal area. There were 3 previous documented choking incidents prior to Mr. Barton's death, on each occasion staff were on hand to assist and no harm occurred. On the 5th February 2013 Keith Barton was eating breakfast in his room when he choked and died. There was no evidence that Mr. Barton had been checked whilst eating his breakfast by any of the staff on duty. The SALT gave evidence at the inquest that by supervision and monitoring she meant constant supervision by someone sitting with him or in close proximity. The nursing home did not ask for clarification of the recommendations communicated in the letter from the SALT which was somewhat ambiguous.
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 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. – (1) That clarification as to the level of supervision and monitoring was not sought from the speech and language therapist in a case where the recommendation required clarification (2) That external training in relation to dysphagia awareness which had been put in place following the death of Mr. Barton could not be delivered to all staff members because of constraints on the number of places available (which could potentially be resolved by in-house training) (3) That incident reports were not completed and therefore a further SALT review had not been triggered (this has been addressed by the nursing home and does not require further action to be taken) (4) That residents at risk of choking were subject to periodic checks (this has been addressed by the nursing home and does not require further action to be taken)
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths (in respect of (1) and (2) above) and I believe 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 31st January 2013. 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 [redacted] I have also sent it the Speech and Language Therapy Team at Kent Community Health NHS Trust 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.
9	**6th December 2013** P J Hardy