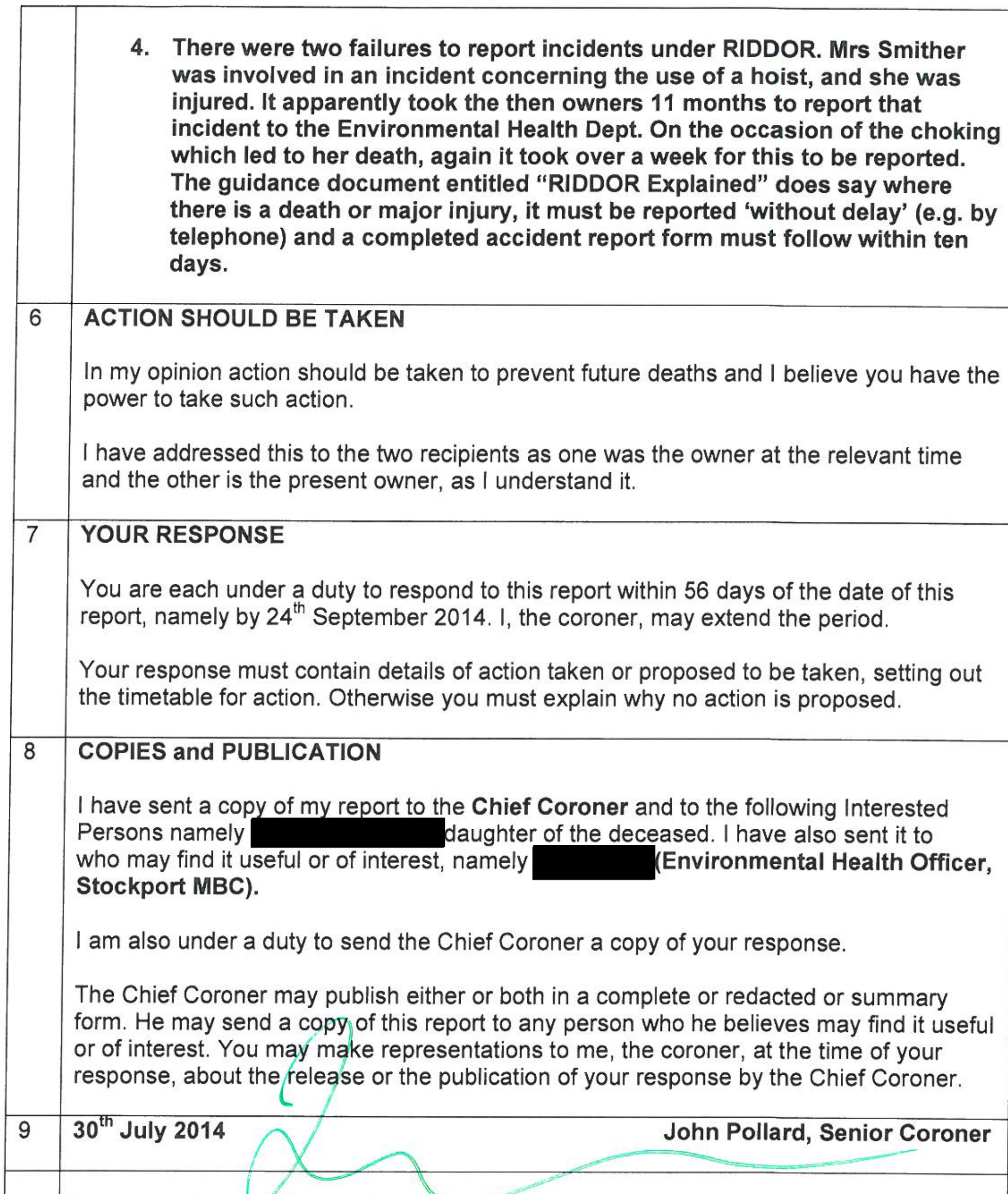
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] Harbour Healthcare, 18,Holt Lane, Halton, Runcorn, Cheshire WA7 2AY** **2. [redacted] United care (North) Limited, Talbot Street, Harle Syke, Burnley, BB10 2 HR**
1	**CORONER** I am John Pollard, senior coroner, for the coroner area of South Manchester
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 1st May 2013 I commenced an investigation into the death of Edna Smither dob 17th May 1920. The investigation concluded on the 30th July 2014 and the conclusion was one of Misadventure. The medical cause of death was 1a Asphyxia 1b Choking on Food.**
4	**CIRCUMSTANCES OF THE DEATH** **On the 25th April 2013 at Peel Moat Care Home in Stockport, the deceased was being fed her lunch consisting of sausage and mashed potato. She choked on the sausage and died later that day in Stepping Hill Hospital.**
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.It transpired during the course of the hearing that only one (comparatively junior) member of staff present on the day of the incident and death, had a First Aid certificate which was 'in date'. Whilst I recognise that there is no legal requirement for this, none the less I feel it would be very helpful for all staff to have up-to-date certification, so that they would know when to, and how to, carry out abdominal thrusts to dislodge food boluses etc.** **2. There was a door which Mrs Smither was to be carried through by the ambulance staff, and this door was locked. A delay occurred whilst this was unlocked. Was this door in fact a fire escape door, and if so has the situation now been changed?** **3. All the staff in attendance, by their own admission, were in a state of panic. No-one, including the senior staff took a position of calm leadership and there seemed to be no training for this nor a recognition as to who really was in charge.**



	4. There were two failures to report incidents under RIDDOR. Mrs Smither was involved in an incident concerning the use of a hoist, and she was injured. It apparently took the then owners 11 months to report that incident to the Environmental Health Dept. On the occasion of the choking which led to her death, again it took over a week for this to be reported. The guidance document entitled "RIDDOR Explained" does say where there is a death or major injury, it must be reported 'without delay' (e.g. by telephone) and a completed accident report form must follow within ten days.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. I have addressed this to the two recipients as one was the owner at the relevant time and the other is the present owner, as I understand it.
7	**YOUR RESPONSE** You are each under a duty to respond to this report within 56 days of the date of this report, namely by 24th September 2014. 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 namely daughter of the deceased. I have also sent it to who may find it useful or of interest, namely **(Environmental Health Officer, Stockport MBC).** 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	**30th July 2014** **John Pollard, Senior Coroner**