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. [redacted] **Director of Adult Social Services, Adult Social Care, Leeds City Council, Merrion House, Leeds, LS2 8DT**
1	**CORONER** I am Jan Alam, assistant coroner, for the coroner area of West Yorkshire (East)
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 19th February 2015 I commenced an investigation into the death of Alison Dawn Evers aged 34 years. The investigation concluded at the end of the inquest on 26th February 2015. The conclusion of the inquest was that the deceased, Alison was in the care of Horsforth Fulfilling Lives Centre at the time. She suffered from Cri Du Chat Syndrome and she had a number of medical problems associated with this, particularly related to feeding. Alison also suffered from scoliosis. She attended Horsforth Fulfilling Lives Centre on a daily basis. Whilst at Horsforth Fulfilling Lives Centre she was dependant on the care staff to meet her personal needs, including feeding. On the 20th April 2012 Alison suffered significant brain damage and cardiac arrest due to the hypoxia she suffered as a result of choking on a sweet that had almost completely obstructed her airways. Despite efforts by the care staff, ambulance crew and the Paramedic Alison did not regain consciousness or show signs of a pulse or respiratory effort of her own. She was transferred to the Accident & Emergency Department at Leeds General Infirmary where further care and treatment was provided. Alison's life was pronounced extinct on 24th April 2012 at 15:05 hours. Her death was contributed to by neglect by a failure to not comply with Independent Support Plan and Risk Assessment in respect of her dietary requirements. Medical cause of death: 1a. Hypoxic brain injury. 1b. Cardio-respiratory arrest. 1c. Obstruction of the airway by a sweet. ii. Cri Du Chat Syndrome.

4	**CIRCUMSTANCES OF THE DEATH** The deceased, in a dependant position whilst in state care, died as a result of choking on a sweet given contrary to her Independent Support Plan and Risk Assessment. The Independent Support Plan and the Risk Assessment clearly stated that Alison had swallowing difficulties and her food is to be liquidised or finely chopped. The healthcare support workers were aware of Alison's risk of choking. The sweet caused an almost complete obstruction to her airway that led to hypoxia followed by a cardiac arrest.
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) The lack of a written 'no treats policy'. (2) The lack of a policy ensuring a first aid trained member of staff is on duty for each shift. (3) Level of first Aid training of health support workers, particularly if working with service users who suffer from cognitive and/or physical impairment and are dependant on carers to meet their personal and dietary needs.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you Leeds City Council 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 the 27th April 2015. 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](parents) 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	**2nd March 2015** [redacted] **JAN ALAM**