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. Mr Tim Cooper, Chief Executive, United Response, Highland House, 165 Broadway, Wimbledon, SW19 1NE
1	**CORONER** I am Alan Peter Walsh, Area 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 13th October 2015 I commenced an Investigation into the death of Lee Joseph Rigby, 45 years, born 7th April 1970. The Investigation concluded at the end of the Inquest on 22nd December 2015. The medical cause of death was 1a) Bronchopneumonia, 1b) Global brain injury, 1c) Cardiac arrest following choking episode. The conclusion of the Inquest was Accident.
4	**CIRCUMSTANCES OF THE DEATH** 1. Lee Joseph Rigby died at Royal Albert Edward Infirmary, Wigan on the 7th October 2015. 2. Mr Rigby suffered with diagnosed Parkinsonism and he had known and recorded swallowing difficulties. 3. Mr Rigby had resided at [redacted] since 2009. The property at [redacted] is a bungalow with three bedrooms and is used as a residence for two residents with support staff giving twenty four hour support and one of the bedrooms is used for support staff that stay overnight. The premises have a living room, kitchen, a disabled shower room and a disabled toilet, in addition to the three bedrooms, and the home is designed specifically for wheelchair users. Support staff is provided by United Response, a registered charity, who provide twenty four support for adults with learning disabilities, physical

disabilities and mental health issues.

4. Mr Rigby had learning disabilities, physical disabilities, behavioural problems, speech and communication problems and he was confined to a wheelchair. He had a tendency not to fully chew his food and he was described as a "lazy eater in that if he got fed up of chewing his food then he would swallow the food whole".

   Recommendations were put in place by the Complex Care Team, including a Speech and Language Therapist, from the Bridgewater Community Healthcare NHS Foundation Trust.

   A Health Action Plan and Management Guidelines were prepared by the Trust and reviewed on an annual basis by the Trust and the most recent Guidelines dated the 29th June 2015 provided that support staff should observe Mr Rigby at all times whilst he was eating and drinking to look out for possible signs of difficulty, including storing food and drink in the mouth and choking.

5. The evidence at the Inquest was that the staffing level provided by United Response at [redacted] was two support staff between 9am and 8pm each day and one support staff between 8pm and 9am overnight. The evidence was that between 9am and 8pm each day one of the support staff may leave the premises for a short time but two support staff should always be present at important times during those hours, which would include meal times. There was a changeover of staff at 12 noon each day in that one support worker would leave the premises at 12 noon at the end of her shift and a new support worker would start a shift at 12 noon but it was expected that the new support worker would arrive at the premises before the other support worker left the premises.

   Members of the support staff did not have a set of keys to the premises and there was no key safe provision outside the premises to allow access to a key for a support worker to gain entry to the premises. Accordingly a support worker would have to answer the door to allow access by another support worker at the start of a shift and at any other time. At such times the support worker answering the door may be the only support worker in the premises.

6. On the 7th October 2015 a support worker left the premises at or about 12 noon at the end of her shift before the replacement support worker had arrived at the premises, leaving one support worker on her own in the premises.

   After the support worker had left the premises and before the replacement support worker had arrived at the premises the remaining sole support worker served Mr Rigby with a sausage roll, which was cut up into small pieces, for lunch. At that time one resident was in the living area and Mr Rigby was sat at the breakfast bar in the kitchen with the sausage roll in front of him.

Mr Rigby would either use cutlery to eat the sausage roll or he was known to grab food by hand to place the food into his mouth.

As Mr Rigby began eating the sausage roll the doorbell to the premises rang and the sole support worker in the premises went to the door to answer the doorbell leaving Mr Rigby alone in the kitchen whilst eating the sausage roll. The replacement support worker was at the door and she was allowed access to the premises by the sole support worker. At or about the same time Mr Rigby, who had been left alone at the breakfast bar in the kitchen, was heard to gag and he was then seen to throw his arms in the air. The support staff realised that Mr Rigby was choking and actions were taken to relieve the choking and the emergency services were called.

The emergency services attended within minutes and Mr Rigby was taken to the Royal Albert Edward Infirmary in Wigan where he died a short time after arrival at the Hospital.

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. During the Inquest evidence was heard that

   i. The support workers do not have keys to the premises at [redacted] so that in circumstances where there was only one support worker in the premises that support worker would have to answer the door to allow another support worker entry to the premises. In those circumstances a resident requiring visual monitoring or observation would be left alone and unobserved.

   Evidence was heard during the course of the Inquest that one of the two support workers could leave the premises during the course of the day so that access to the premises would be required by a support worker either at the commencement of her shift or whenever the support worker left the premises at times when there would only be one support worker in the premises.

   It was accepted that if every support worker had a key to the premises the sole support worker in the premises would not have to be disturbed to answer the door and a resident, like Mr Rigby, would not be left unattended at meal times, when Mr Rigby had to be observed at all times, and at any other times whenever he was eating and drinking.

   ii. Evidence was heard from the support staff that they did not fully understand that monitoring and observing Mr Rigby at all times

when he was eating and drinking meant that they should visually observe him at those times.

Evidence was also given by members of the support staff that if the telephone rang and there was a need to discuss a resident or something of a private and confidential nature a support worker, who may be the only support worker in the premises at the time, would go into another room to talk in a private and confidential manner, leaving a resident alone and unobserved during the course of the telephone conversation.

The support staff did not understand the significance of the words used in the Health Action Plan and Management Guidelines that Mr Rigby should be observed at all times whilst he was eating and drinking and they did not fully understand the significance of observing him in relation to the risks identified in the Plan and Guidelines.

iii. The internal training and procedures provided by United Response to the support staff and the procedures in place to address the risks identified by the Health Action Plan and Management Guidelines did not address the risks identified by the Plan and the Guidelines, particularly in relation to a clear understanding by the support staff with regard to observing a resident.

iv. The evidence raised concerns that there is a risk that future deaths will occur unless action is taken to review the above issues.

2. I request you to consider the above concerns and to carry out a review with regard to the following:-

i. The provision of keys to each member of the support staff at [redacted] and any other premises operated by United Response to allow support staff access to premises without disturbing other support workers working in the premises.

ii. The adequacy of support staff in premises, in terms of numbers and experience, to satisfy the requirements of Care Plans or Health Action Plans and Management Guidelines, which highlight the risks to be addressed by support staff and United Response.

iii. A review of all procedures operated by United Response in relation to risks identified by Care Plans or Health Action Plans and Management Guidelines.

iv. The training of all staff employed by United Response with particular focus on the understanding of staff in relation to the risks and procedures identified by Care Plans and Health Action Plans and Management Guidelines so that there is no

	misunderstanding with regard to the provisions of such Plans and Guidelines and the actions to be taken by support workers.	
6	**ACTION SHOULD BE TAKEN** In my opinion urgent 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 10th March 2016. 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 1. [redacted] Mr Rigby's sister. 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	**Dated** **14th January 2016**	**Signed** **Alan P Walsh**