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], Acting Chief Executive, BUPA House, 15-19 Bloomsbury Way, London WC1A 2BA **2.** [redacted] Manager, Mill View Nursing Home, Bridgeman Street, Bolton BL3 6SA **3.** The Right Hon Jeremy Hunt MP, House of Commons, London SW1A 0AA
1	**CORONER** I am Professor M Jennifer Leeming, HM 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 the 20th of November 2015 I commenced an investigation into the death of Margaret Rogerson, 91 years, born 29 November 1923. The investigation concluded at the end of the Inquest on the 20th April 2016. The conclusion of the Inquest was a combination of Natural Causes and Accident.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances as found by the Jury were:- Mrs Margaret Rogerson, known as Peggy, who due to her Alzheimer's Disease, was subject to a Deprivation of Liberty Safeguarding Authorisation. Peggy died on the 11th November 2015 at Victoria House, Mill View Care Home, Bolton of asphyxia due to aspiration of pureed food, whilst being fed. The progression of the Alzheimer's Disease, almost certainly caused her normal cough and epiglottis reflexes to no longer function, as explained by the Pathologist, which led to the aspiration and therefore the asphyxia.

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: During the Inquest evidence was heard that:- 1. A Care Assistant giving evidence at the Inquest could not recall having been trained in the mechanisms of and techniques of how to feed a patient. Particularly there was no evidence of any training relating to the risks involved in feeding patients nor as to the risks created by particular conditions from which patients were suffering. 2. There was no evidence of there being any refresher training in the above matters. 3. There was no evidence of there being any training available to family members and others close to patients in the above matters. There was clear and striking evidence that family members and others would appreciate such training being available to them because in patients with advanced dementia feeding was often the only communication available between patients and their loved ones. There was also evidence that being able to do this in a professional and safe manner would be a great comfort to patient's relatives and loved ones, who would as a result feel that they themselves were doing something meaningful for the patient.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe you and 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 12th July 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] (Mrs Rogerson's daughter) 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** **21st April 2016**	**Signed** **Professor Jennifer M Leeming** **HM Senior Coroner**