IN THE SURREY CORONER'S COURT IN THE MATTER OF:

The Inquests Touching the Death of Geraldine Butterfield A Regulation 28 Report – Action to Prevent Future Deaths

THIS REPORT IS BEING SENT TO:

Collingwood Grange Nursing Home Portsmouth Road Collingwood Grange Close Camberley GU15 1LD

1 | CORONER

Ms Anna Crawford, HM Assistant Coroner for Surrey

2 | CORONER'S LEGAL POWERS

I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.

3 INVESTIGATION and INQUEST

The inquest into the death of **Mrs Butterfield** was opened on the 5 August 2015 and was resumed and concluded on the 24th January 2017. The cause of death was:

1a – Asphyxia due to food inhalation.

The inquest concluded with a narrative conclusion.

4 CIRCUMSTANCES OF THE DEATH

Mrs Butterfield was a resident at Collingwood Grange nursing home in Camberley. The nursing home is run by BUPA Care Services Limited and Mrs Butterfield's placement was funded by Surrey County Council.

On 25 July 2015 Mrs Butterfield was eating her lunch in the dining room when she was noticed to be slumped over in her wheelchair. A nurse attended and checked Mrs Butterfield's mouth and did not see any food, she positioned her so as to maintain her airway and slapped her on the

back. She then arranged for Mrs Butterfield to be wheeled to her bedroom where she was placed in the recovery position on her bed. Another nurse then repeatedly slapped Mrs Butterfield on the back and used a suction machine to remove food from her mouth and the opening of her throat. The court heard evidence that the suction machine was not capable of removing food from Mrs Butterfield's airway. Mrs Butterfield was then placed on the floor in preparation for carrying out Cardio-Pulmonary Respiration (CPR). However, CPR was not ultimately attempted because Mrs Butterfield had a valid Do Not Attempt to Resuscitate (DNAR) order in place, and her death was confirmed by attending paramedics at 13:09. The court heard evidence that repeated back blows were not attempted until Mrs Butterfield had been transferred to her room and placed on the bed and that no attempt was made to carry out any abdominal thrusts, in contravention of the BUPA policy on choking.

5 | CORONER'S CONCERNS

Having heard evidence from a number of members of the nursing staff, I am concerned that not all staff members have a sufficient knowledge and understanding of the BUPA policy on choking, so as to be able to effectively implement it in the future. I am also concerned that not all staff members have a sufficient understanding of when potentially life-saving treatment should be provided to individuals in respect of whom a DNAR order is in place.

The MATTERS OF CONCERN are:

- Not all staff members have a sufficient knowledge and understanding of the BUPA policy on choking so as to be able to effectively implement it in the future.
- Not all staff members have a sufficient understanding of when potentially life-saving treatment should be provided to individuals in respect of whom a DNAR order is in place.

Consideration should be given to whether any steps, including further training, can be taken to address the above concerns.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.

7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of its date; I may extend that period on request.

Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.

8 COPIES

I have sent a copy of this report to the following:

- 1.
- 2. Surrey Heath Locality Team, Surrey County Council
- 3. Care Quality Commission
- 4. The Chief Coroner

Signed:

ANNA CRAWFORD

DATED this 25 day of January 2017