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 Nick Dykes, Chief Executive of CLS Care Services, Nantwich, Cheshire
1	**CORONER** I am Rachael Clare Griffin, Assistant 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 28th January 2016 I commenced an investigation into the death of Joyce Crompton, born on the 20th March 1936. The investigation concluded at the end of the Jury Inquest on the 2nd December 2016. The Medical Cause of Death was: Ia Airway Obstruction b Regurgitated food in the mouth and pharynx II Vascular Dementia The conclusion at the Inquest was Choking on regurgitated food, with the underlying cause of Vascular Dementia.
4	**CIRCUMSTANCES OF THE DEATH** On the 26th January 2016 Joyce Crompton was found in an unresponsive condition in the bathroom of her room at her place of residence at Belong Village, 55 Mealhouse Lane, Atherton. She had been eating her evening meal prior to this in the dining area. She got up from the table and was later found in her room with food in her mouth and food on the floor beside her. Prior to her death she had been witnessed to have two incidents of choking. One on the 14th September 2015 and one on the 10th December 2015. On the latter occasion the paramedics and out of hours GP had attended. The GP had advised that she should be referred to the Speech and Language Therapy (SALT) Team for assessment of her swallowing. This was not done. At the time of her death

	Joyce was the subject of a Deprivation of Liberty Safeguarding Authorisation.
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. During the inquest evidence was heard that: i. When a resident at Belong Village chokes there should always be a referral to the SALT team to assess their swallowing. A fax is sent by the home to the GP who then will submit a referral to the SALT team. Once the fax has been sent to the home the staff will chase up the referral by telephone. If a referral is done it will be recorded in the GP healthcare visits section of the resident's notes. ii. There is no written policy or procedure in place and staff are given verbal advice on referrals to outside agencies, such as SALT, when they start working at the home. There is no systematic checklist to complete to ensure a referral has been done or to confirm when the referral has been chased. iii. After the witnessed choking incident Mrs Crompton experienced at Belong Village on the 14th September 2015 a referral was not sent to the GP or to SALT. iv. After the witnessed choking incident Mrs Crompton experienced on the 10th December 2015 at Belong Village, a referral was not made to the GP or to SALT. It was recorded in the notes and the home diary that a referral to SALT was to be done, but none of the staff did the referral. The staff who gave evidence at the Inquest all confirmed that they had presumed that it had been done, however there was no record on the GP Healthcare visits sheet that a referral had been done. I have concerns with regard to the following: i. It is clear that although there is verbal training given on referrals to outside agencies, such as SALT, there is no written guidance that can be easily referred to when incidents arise. There is also no refresher training on the policies. Due to this there may be another occasion in the future when a referral to the SALT team is missed which could result in a future death. ii. I therefore request that a review is undertaken of the policies, procedures and training in place at Belong Village in relation to referrals to the SALT team to avoid future referrals being missed.

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, 31st January 2017. 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 Crompton's son on behalf of the family (2) Hill Dickinson LLP on behalf of the Speech and Language Therapy team (3) The Care Quality Commission, North Region I am also under a duty to send the Chief Coroner a copy of your response. I have also sent a copy to Wigan Borough Clinical Commissioning Group, Wigan Life Centre, College Avenue, Wigan, WN1 1NJ. 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** **6th December 2016**
	Signed **Rachael C Griffin**