	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Care Quality Commission** **2. Department of health** **3. NHS England** **4. Jubillee Gardens care home** **5. Aran Court Care Centre**
1	**CORONER** I am Louise Hunt Senior Coroner for **Birmingham and Solihull**
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 10/02/2016 I commenced an investigation into the death of Robert Arthur Davidson aged 79. The investigation concluded at the end of an inquest on 12th October 2016. The conclusion of the Jury at the inquest was We do not deem Roberts death to be an accident. Our narrative conclusions are: 1. Roberts PICA condition was inadequately identified during the pre-admission process. 2. Insufficient attention was paid to the 28/03/15 risk assessment during handover between care providers. 3. Lack of escalation of the 13/11/15 incident when Robert was seen eating a glove, did not result in the correct procedure being followed and Roberts needs being sufficiently met in respect of 1:1 care. 4. The level of training for staff dealing with vulnerable people was insufficient. 5. There was a failure to ensure staff were suitably trained for emergency situations. In particular: summonsing help, calling emergency services or when to initiate CPR. His death was contributed to by neglect..
4	**CIRCUMSTANCES OF THE DEATH** The deceased suffered from dementia and Altzeimers disease. Due to his complex care needs he was admitted to Jubilee Gardens care home on 20/03/15. Due to concerns from the family and the home being an unsuitable placements he was transferred to Aran Court Care Centre on 03/04/15. At Jubilee gardens a risk assessments had been undertaken identifying the deceased as suffered from PICA. This is when someone puts objects other than food into their mouth and they then try to eat these objects. During the transfer this fact was not recognised or highlighted. On 13/11/15 the deceased was found "eating" a plastic glove. The staff member on duty failed to report this to the Home Manager, who confirmed she would have put 1:1 nursing in place to avoid a similar occurrence. On the evening of 27 January 2016 at approximately 22.10, the deceased was found choking sitting in a chair in the corridor. Staff were initially unable to remove the obstruction. A 999 call was made at 22.15 indicating that the deceased was unresponsive and blue. No CPR was instigated despite being instructed by ambulance call staff to do so. A paramedic arrived at 22.23 and immediately started CPR as the deceased was in cardiac arrest. He was taken to Heartlands Hospital where he was pronounced dead. Following a post mortem/Based on information from the Deceased's treating clinicians the medical cause of death was determined to be: OBSTRUCTION OF AIRWAY BY PLASTIC GLOVE

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 I heard evidence that Health care staff had not been trained on basic process as follows: • Making 999 calls – to obtain an outside line caller's needed to first dial "9". The HCA instructed to make the 999 call did not know this so the call was unsuccessful. The registered nurse looking after the patient whilst he was choking had to make the 999 call resulting in her leaving the patient. • When to Start CPR. The RGN and HCA (Health Care Assistants) staff had received no training on the CPR and choking policy The concern is that staff are not trained in basic processes and therefore not able to deal with emergency situations. 2. The two HCA's had no experience or basic training before starting work as HCA's. They had limited understanding of conditions and processes. Consideration needs to be given as to whether there should be mandatory training or minimum standards, which are objectively assessed, to ensure HCA's have the necessary knowledge and understanding to undertake their role. 3. The deceased PICA behaviour was not highlighted or identified on his transfer between care homes. Some process or direction from the governing body needs to be provided to care homes to ensure essential information is provided and highlighted when patients are transferred.
	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you 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 12 December 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 family of the deceased. 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	13 October2016 Signature_____ Louise Hunt Senior Coroner **Birmingham and Solihull**