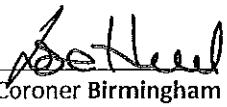
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Boldmere Court Care Home** **2. Care Quality Commission** **3. Department of Health**
1	**CORONER** I am Louise Hunt Senior Coroner for **Birmingham and Solihull**
2	**CORONER'S LEGAL POWERS** I make this report under 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 15/08/2016 I commenced an investigation into the death of David Sheppard who died at Good Hope Hospital on 03/08/16 aged 66. The investigation concluded at the end of an inquest on 5th May 2017. The conclusion of the Jury at the inquest was "On 31st July 2016, inadequate action was taken to help the deceased from choking. Failure to give appropriate medical assistance in an immediate timeframe. A lack of training and communication between caregivers ultimately resulted in the deceased being rushed to Good Hope Hospital where he later passed away due to a severe hypoxic brain injury. In conclusion his death was contributed to by neglect.."
4	**CIRCUMSTANCES OF THE DEATH** The deceased suffered from vascular dementia and a previous stroke. He became a resident at Boldmere Court in July 2013. He had challenging behaviour and was cared for on the challenging behavioural unit however, he was able to verbally communicate his needs. On 31/07/16 he was given a doughnut at 23:22 and went back to his own room. Soon after he was found by a carer outside his room, pointing at his throat and unable to communicate verbally. The carer took the deceased back into his room, leaving to find the nurse who was on another floor. During this time another carer checked on the deceased and raised the emergency alarm at 23:38. Various members of staff attended, including 2 nurses who entered the room. A nurse checked the deceased's airways which appeared clear, however the deceased still had breathing difficulties and could not communicate. The first ambulance call was placed at 23:41 stating the deceased was having difficulty breathing. Staff brought crash mats into the deceased's room. In this period all members of staff who initially attended the alarm call, continually left and re-entered the room until 23:48 when CPR commenced by a carer. Soon after starting CPR a piece of doughnut came out of the deceased's mouth. There were points during this time where the deceased was left alone. At 23:49 a second ambulance call was placed, stating the deceased was now in cardiac arrest and not breathing. The ambulance arrived 6 minutes later. When the paramedics arrived there was no CPR in progress and no airway assisting the deceased's breathing. The paramedics noted the deceased had agonal breathing. They took over care and resuscitated the deceased several times. The deceased was then taken to hospital where he arrived with a pulse and a Glasgow coma score of three. The deceased was treated in A&E where food particles were found in the airway. The deceased was resuscitated and taken to ITU where he was found to have suffered a severe Hypoxic Brain Injury as a result of the cardiac arrest which was caused by choking on a doughnut. Following this, a decision was made to withdraw treatment and let nature take its course. The deceased later died at Good Hope Hospital on the 3rd August 2016. Following information from the Deceased's treating clinicians the medical cause of death was

	determined to be: 1a. HYPOXIC BRAIN INJURY 1b. CARDIAC ARREST 1c. CHOKING 2. VASCULAR DEMENTIA, HYPERTENSION
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. **Communication.** There are three areas where communication is a concern: a. The initial nurse who attended the deceased after the emergency call had poor English and needed to give evidence at the inquest through an interpreter. The carer who started CPR had very poor English and also gave evidence through an interpreter. The evidence heard at the inquest was that the response to this emergency was chaotic. Inability of staff to communicate with each other contributed to the chaos and poor decision making. b. Staff failed to pass on an accurate history of what had happened to the deceased resulting in there being a poor understanding of his initial complaint – namely that the deceased was pointing to his throat and was unable to communicate. These factors would indicate choking. c. The patients on the challenging behavioural unit are extremely vulnerable and many suffer from dementia and other conditions. Staff being unable to communicate effectively with these patients may cause harm and confusion. 2. **Record keeping.** Staff failed to keep an acute and contemporaneous note of the events that occurred with timings. This made reconstruction of the event extremely difficult. 3. **Training.** Several of the staff who gave evidence had not received first aid training. They did not understand the signs of choking displayed by the deceased. 4. **Post event investigation.** The quality of statements produced by staff immediately after the event was extremely poor. Subsequently staff had a very poor recollection of what happened which seriously hampered the inquest. Direction needs to be given to ensure that accurate and contemporaneous statements are taken after such an incident to ensure events are accurately recorded to enable the correct lessons to be learnt.
6	**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 3 July 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 The family [redacted] I have also sent it to Nursing and Midwifery Council who may find it useful or of interest. 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	08/05/2017 Signature  Louise Hunt Senior Coroner **Birmingham and Solihull**