REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] Home Manager, Hilltop Court** **2. Manager, Harbour Healthcare Limited** **3. Care Quality Commission**
1	**CORONER** I am Rachel Galloway, assistant coroner, for the coroner area of South Manchester
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 23rd October 2017 an inquest was opened into the death of Barbara Haley. The inquest took place on the 29th March 2018 and the conclusion was one of Natural Causes. The medical cause of death was: 1a Aspiration Pneumonia 1b Alzheimers Dementia
4	**CIRCUMSTANCES OF THE DEATH** On the 13th October 2017 or in the days prior, Mrs Haley had inhaled either vomit, saliva, food or liquid whilst resident at Hilltop Court Care Home. This led to the development of a chest infection and her condition deteriorated suddenly on the morning of the 13th October 2017. An ambulance was called and she was transported to Stepping Hill Hospital but suffered a cardiac arrest on route and passed away at Stepping Hill Hospital on the morning of the 13th October 2017.
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. – Whilst these matters did not contribute to Barbara Hayley's death, they did reveal matters giving cause for concern in respect of the risk of future deaths: 1. Mrs Haley was on a soft diet (described as a "fork-mashable diet" in evidence). Despite this, there was evidence that Mrs Haley had been provided with food items not suitable for her by staff. In particular, on one occasion toast was found in her room. On another occasion, staff had apparently suggested to a family member that chocolate could be given to Mrs Haley.

	2. During the course of her evidence, [redacted] (Home Manager) explained that Mrs Haley was assessed as being at High Risk of choking and scored highly on the risk assessment that had been carried out. Despite this, Mrs Haley would be left alone in her room to eat because [redacted] stated) she did not like to have staff present when she was eating; she would then refuse to eat. We heard evidence from a manager at another home that Mrs Haley would eat when she was in the dining room with other residents, where staff could also observe her. It was of concern that Mrs Haley was being left alone in her room to eat when she had been assessed as being at high risk of choking.
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 29th May 2018. 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 family of Mrs Haley 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	Rachel Galloway HM Assistant Coroner 03/04/2018