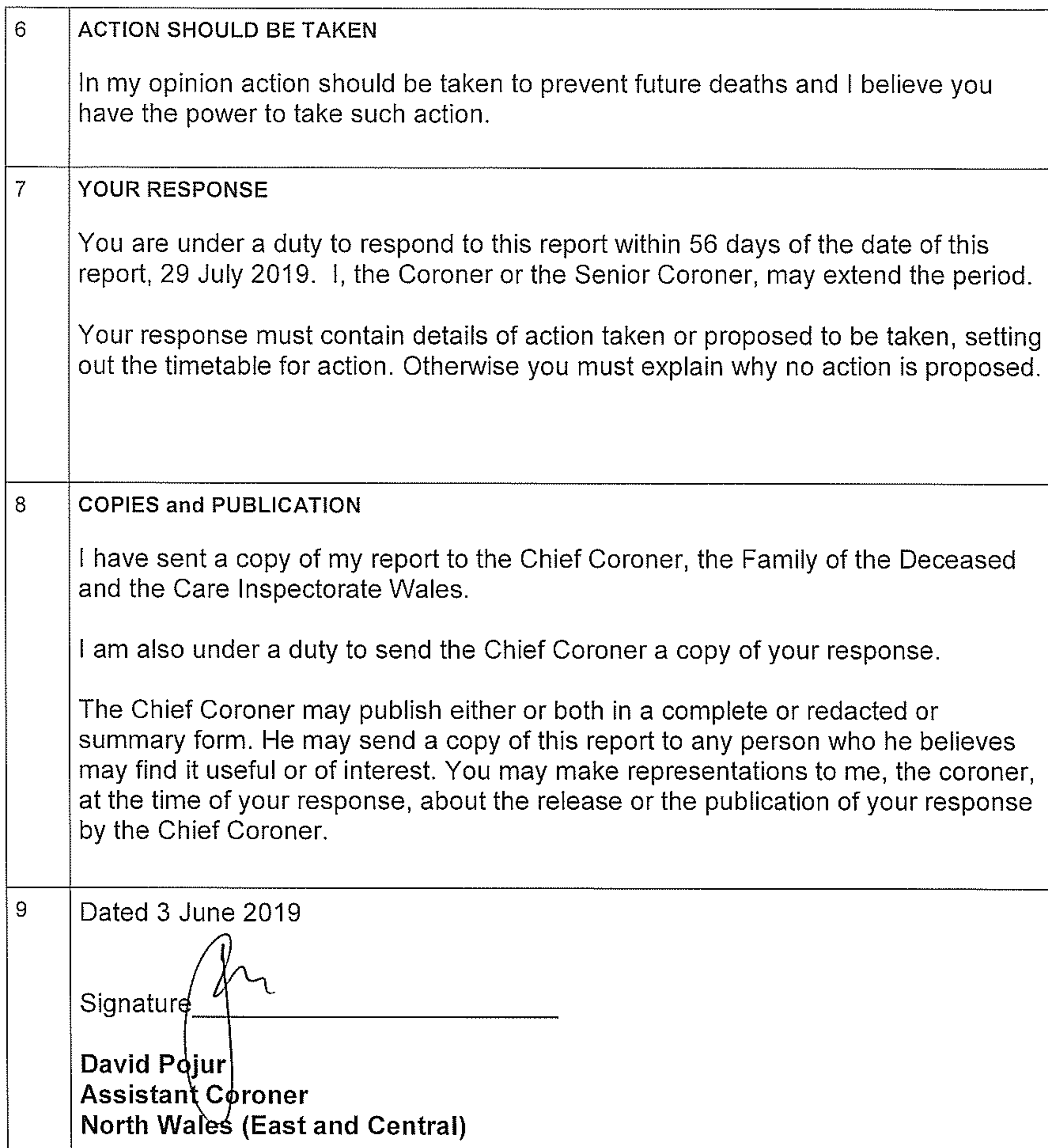
Mr David Pojur
Assistant Coroner
North Wales (East and Central)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Coed Duon Care Home, Halkyn Road, Hollywell, Flintshire, CH8 7SJ
1	CORONER I am David Pojur, Assistant Coroner for North Wales (East and Central)
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 21 May 2018 this Court commenced an investigation into the death of Kathleen Smith (DOB 04.12.33 DOD 12.05.18). The investigation concluded at the end of the inquest before me on the 12 April 2019. The Conclusion of the inquest was delivered by way of a narrative stating: Kathleen Smith died at Coed Duon Nursing and Residential Home on 12 May 2018. She had advanced dementia and was at risk of choking. She needed a pureed diet. Staff had not received sufficient training and fed her unsuitable food. She began coughing and was aspirating. A nurse was called to her room and staff did not examine or assist Kathleen Smith. She aspirated on the food material and died thereafter. The Cause of Death is recorded as: 1(a). Aspiration of Food Material 1(b). Right Sided Early Pneumonia 2. Dementia and Astma

4	CIRCUMSTANCES OF THE DEATH Kathleen Smith required one to one care for food and fluids and entered the Home with a known risk of choking for which there was a risk assessment on her file. She was on a fluid thickened diet and pureed food diet. The part time carer who fed her breakfast had no suitable training to do so nor knowledge surrounding her food and fluid needs. The carer only had manual handling training. Inappropriate food was fed to Mrs Smith. She was coughing and help was summoned. There was poor communication between staff as to the nature of the emergency. Whilst a nurse and another senior member of staff attended, they did not assist Mrs Smith. Instead paper work was checked and telephone calls were made. 999 was not called.
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. Staff were not sufficiently trained in first aid or how to assist a resident who was at risk of choking. 2. Staff did not intervene to assist the resident for whom the internal emergency alarm had been sounded as help was needed. 3. Staff were not sufficiently trained in how to select and prepare correct foods and fluids for residents with special dietary needs and who had a documented risk of choking. 4. The above training remains incomplete approximately 11 months after the death of Mrs Smith. 5. Staff could not demonstrate they understood how to deliver safe care and treatment regarding food and fluids and manage the risk of choking. 6. There is no adequate management oversight to ensure staff are appropriately deployed to those residents at risk of choking and or who require one to one assistance with food and fluids.



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, 29 July 2019. I, the Coroner or the Senior 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, the Family of the Deceased and the Care Inspectorate Wales. 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	Dated 3 June 2019 Signature____________________ **David Pojur** **Assistant Coroner** **North Wales (East and Central)**

Coroner's Office, County Hall, Wynnstay Road, Ruthin, LL15 1YN
Tel 01824 708047 | Fax 01824 708048