	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1) CHIEF EXECUTIVE OF UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST**
1	**CORONER** I am Adam Hodson, Assistant 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 17/05/2019 I commenced an investigation into the death of Prabhaker Nath Kapoor. The investigation concluded at the end of an inquest on 5th August 2019. The conclusion of the inquest was that of a Narrative Verdict, namely, "death due to aspiration of unthickened fluids in hospital."
4	**CIRCUMSTANCES OF THE DEATH** On 19/11/18, the deceased had an unwitnessed fall at home and was admitted to the Emergency Department at Birmingham Heartlands Hospital where he was diagnosed with a fractured neck of the right humerus. He was to be admitted to Ward 24 where the fracture was to be treated conservatively using a brace. He developed pneumonia due to aspirating food and was treated with IV antibiotics. He had previously been assessed in March 2017 by speech and language therapists in the community for a pureed diet and thickened fluids due to dysphagia caused by previous stroke, and a Feeding At Risk form was completed upon admission to Ward 24 on 19/11/2019 for this diet to continue. At 04.55 on 21/11/18, he was found by a member of staff attempting to drink from an unthickened jug of water which had been left near his bedside. He aspirated an unknown quantity of the contents which contributed to his aspiration pneumonia. His condition rapidly deteriorated as a result of this, and despite appropriate treatment, he died and his death was verified at 08.10 on 21/11/18.. Following a post mortem, the medical cause of death was determined to be: 1a) ASPIRATION PNEUMONIA 1b) INHALATION OF LIQUID 2) FRAILTY
5	**<u>CORONER'S CONCERNS</u>** 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. – I heard evidence that a review of safer swallowing training was to be provided to staff on team training days, and that changes would be made to the MOODLE training package by the Speech and Language Manager. The RCA report carried out by Matron [redacted] indicated that this should have been completed by 15th May 2019, but in oral evidence it was revealed that this had not been done, and an estimated timeframe for completion could not be provided to me. Whilst it was suggested that confirmation could be submitted to HM Coroner upon successful completion of this review, HM Coroner would be *functus officio*. I therefore suggest that the Trust consider carrying out this review of safer swallowing and update the MOODLE training package as a matter of urgency.
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 1st October 2019. 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) Next of Kin of the deceased 2) NHS England 3) Clinical Commissioning Group 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	06/08/2019 Signature  Adam Hodson Assistant Coroner **Birmingham and Solihull**