REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** Paul Mancey, Chief Executive, Orchard Care Homes The Hamlet, Hornbeam Park, Harrogate, HG2 8RE
1	**CORONER** I am Alan Peter Walsh, Area Coroner, for the Coroner Area of Manchester West
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 23rd April 2015 I commenced an Investigation into the death of Thomas Nicholls, 87 years, born 4th July 1927. The Investigation concluded at the end of the Inquest on 20th August 2015. The medical cause of death was 1a. Aspiration Pneumonia, 1b. Ischaemic Stroke. The conclusion of the Inquest was that Thomas Nicholls died as a consequence of a combination of naturally occurring disease and a recognised complication of PEG feeding by Gastrostomy.
4	**CIRCUMSTANCES OF THE DEATH** 1. Thomas Nicholls died at The Salford Royal Hospital, Eccles Old Road, Salford on the 14th April 2015. 2. Mr Nicholls had suffered a Myocardial Infarction in 2011 and a Stroke in May 2014 and his condition markedly deteriorated from the time of the Stroke. 3. In October 2014 Mr Nicholls suffered a further Stroke and he suffered significant right sided weakness with swallowing difficulties. He was admitted to Salford Royal Hospital where he had a Gastrostomy for PEG feeding due to poor coordination of his swallowing. He was discharged from Salford Royal Hospital, Salford on the 15th January 2015 when he became resident at Arden Court Care Centre, Half Edge Lane, Eccles, Salford.

4. On the 17th January 2015 the General Practitioner was concerned that Mr Nicholls was vomiting and he was taken back to Salford Royal Hospital by ambulance. He was discharged from the hospital in the early hours of the following morning and his PEG feed was started the following day but vomiting was still noticed.

5. On the 29th February 2015 Mr Nicholls suffered projectile vomiting and he was taken to the Salford Royal Hospital but returned to Arden Court in the early hours of the following morning.

6. On the 16th March 2015 he had a further episode of vomiting witnessed b[redacted] Mr Nicholls' daughter, and from that day onwards he had further incidents of vomiting and he deteriorated.

7. On the 8th April 2015 Mr Nicholls was taken to the Salford Royal Hospital again and it was noted that he had been unwell for three weeks and there was a history of abdominal distention with increased PEG feeding. Following examination and investigation it was felt that Mr Nicholls had multi organ failure secondary to pneumonia which was believed to be due to aspiration, particularly in view of the fact that there had been recurrent episodes of vomiting since the time of the institution of PEG feeding. The Consultant Physician commented that there had been recurrent pneumonia probably with aspiration despite a PEG tube being in situ and there is a further comment that a PEG tube does not prevent aspiration of oral or gastric secretions and it is quite common for patients to aspirate gastric secretions even with a feeding tube present. It was felt appropriate to continue on supportive care with intravenous fluids, antibiotics and oxygen to prevent aspiration under those circumstances was not possible.

8. Mr Nicholls remained at the Salford Royal Hospital where treatment with intravenous fluids and antibiotics continued but Mr Nicholls deteriorated and died on the 14th April 2015.

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 evidence was heard that

   i. On the 16th March 2015 Mr Nicholls' daughter, [redacted], visited Mr Nicholls at Arden Court to accompany Mr Nicholls to a hospital appointment. Mrs Mellor gave evidence that when she attended at 09.15hrs on that day her father was lay flat on the bed and it looked as if someone had been getting him ready for the hospital appointment but had been interrupted.

Mrs Mellor knew that her father should not be laid flat whilst PEG feeding was in progress and she tried to find the remote control to adjust the angle of the bed without success.

Mrs Mellor saw some feed in Mr Nicholls' mouth and she gave evidence that he was violently sick with projectile vomiting. She asked a Carer about the angle of the bed and PEG feeding but the Carer informed Mrs Mellor that she had not been trained in PEG feeding.

ii. It was clear from the evidence that care staff had indicated that they had not been trained in relation to PEG feeds, particularly in relation to mobility and handling of residents during PEG feeding and the incident on the 16th March 2015 had not been reported to the Manager of Arden Court, who had not considered either training or re-training in relation to PEG feeds.

The Manager gave evidence at the Inquest that he was not aware of the incident on the 16th March 2015 until he heard the evidence at the Inquest and he had only become aware of the details of the incident during the course of the Inquest. He confirmed that there had been no review of training particularly in relation to mobility, handling and the care of residents on PEG feeding regimes.

iii. Evidence was heard that residents may have to be laid flat at times whilst receiving PEG feed but there were controls to allow the feed to be placed on hold whilst mobilising and handling a resident. The care staff did not appear to be fully conversant with the controls of the PEG feed.

iv. The remote control to operate the bed occupied by Mr Nicholls did not function due to the plug having been detached or the junction box having been smashed.

v. The Manager was not aware of the incident on the 16th March 2015 and the incident did not appear to have been recorded so that any training needs in relation to staff, together with a review of risk assessments did not take place after the incident.

vi. The evidence raised concerns that there is a risk that future deaths could occur unless action is taken to review the above issues.

2. I request you to consider the above concerns and to carry out a review of the policies and protocols with regard to the following:

i. The training of care staff in relation to the mobility, handling and care of residents on PEG feed regimes.

ii. The written recording of incidents in relation to PEG feed regimes, particularly in relation to episodes of vomiting and equipment malfunction, to enable risk assessments to be reviewed, equipment malfunctions to be investigated and a review of any staff training

	needs.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe you and your organisation 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 6th November 2015. 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 [redacted] Mr Nicholls's daughter I am also sending a copy of my report to the Care Quality Commission. 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** **11th September 2015**
	Signed **Alan P Walsh**