REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Normanton Village View Nursing Home, Derby; 2. Rushcliffe Care; 3. Care Quality Commission; 4. Chief Coroner; and 5. Family of the deceased.
1	**CORONER** I am Emma Serrano, Assistant Coroner, for the Coroners Area of the Derby and Derbyshire.
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 3rd August 2017, I commenced an investigation into the death of Mr Kenneth Clarke. The investigation concluded at the end of the inquest on 25 February 2020. The conclusion of the inquest was misadventure contributed to by neglect of the Nursing Home Mr Kenneth Clarke was resident in. The cause of death was: 1a Inhalation of food material.
4	**CIRCUMSTANCES OF THE DEATH** i) Mr Clarke was a 74 year old gentleman who was resident in Normanton Village View Nursing home. His past medical history included strokes, which had left him with issue swallowing, and thus a high risk of chocking. He also suffered with dementia. He was on a puree only food diet but his dementia meant he did not appreciate this and would often wonder round the home in search of food. ii) Mr Clarke had been risk assessed by the home and to reduce his risk of choking, measures were put in place. Firstly, he was on a puree food diet. Secondly, he had a he had a pressure sensor mat to the side of his bed to alert staff when he left his room. Thirdly, staff were to be stationed at observation points around to observe if patients left their rooms. Fourthly, the kitchen, where food could be accessed, was to be locked and had a pin operated lock was in place. Finally, food was to be kept in cupboards in the kitchen or in the fridge.

	iii) On the 23rd July 2017 Mr Clarke left his room. The pressure sensor mat did not activate. It is not clear whether this was because it was not working. Whether it was in the correct place, or whether Mr Clarke moved it himself. The staff at the home were not at the designated observation points and did not see him leave his room. He made his way to the kitchen, which was unlocked. He ate a piece of bread that had been left out and not put away in a cupboard or fridge. He choked and died.
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. Evidence emerged during the inquest that Normanton Village View Nursing Home had no formal policies covering how residents were to be observed, how foods were to be stored, locks on the kitchen and cupboards, dementia residents or residents on a liquid food diet.
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. 1. You may wish to consider a review of the policies governing Normanton Village View Nursing Home and other Homes within the group.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 16 April 2020. 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. Family of the deceased; 2. Normanton Village view Care Home; 3. Rushcliffe care; and 4. 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	**27 February 2020**

	E Serrano **Miss Emma Serrano** **Assistant Coroner** **Derby and Derbyshire Coroners Area**