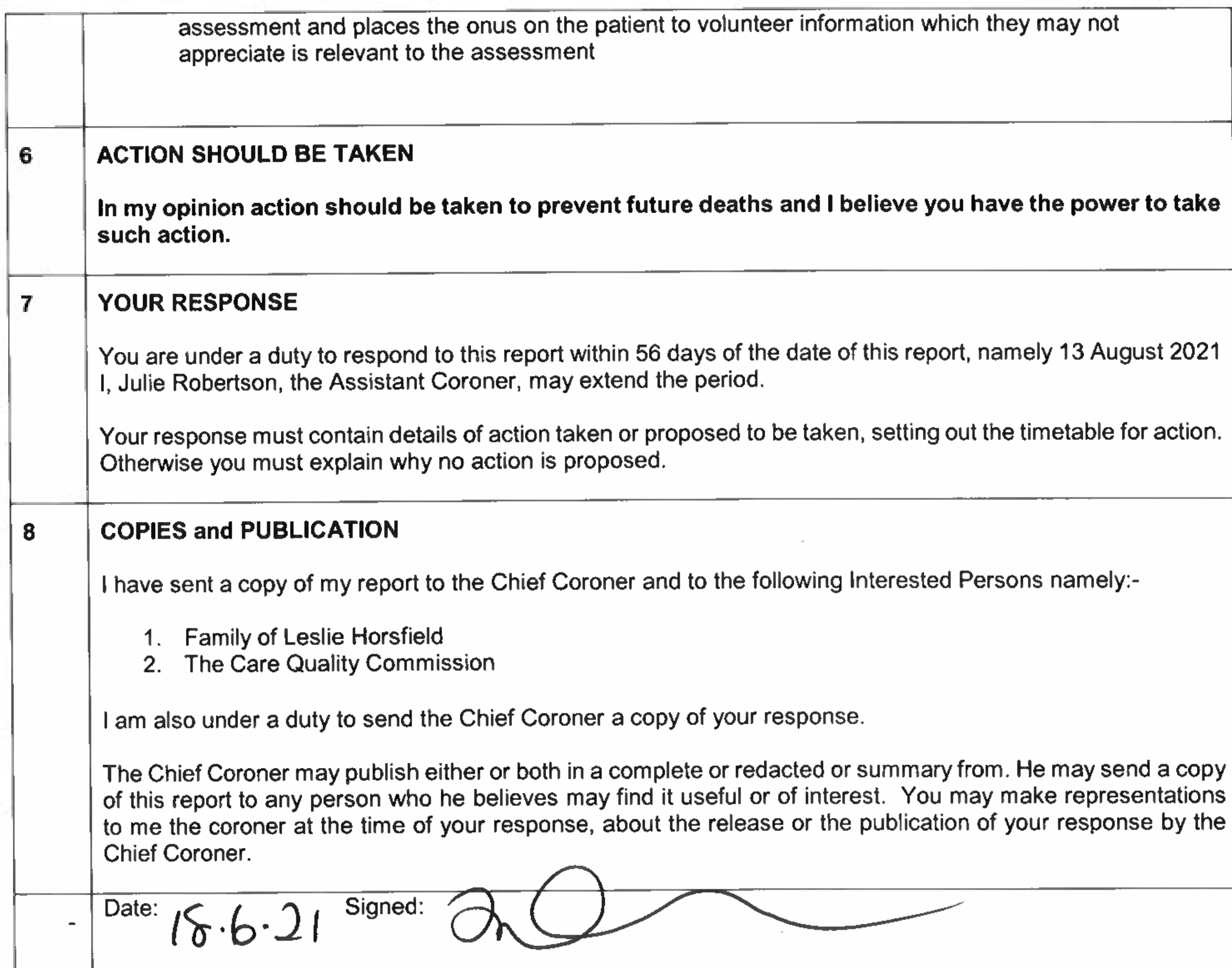
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Chief Executive, The Northern Care Alliance NHS Trust
1	**CORONER** I am Julie Robertson, Assistant Coroner for the Coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On 9 October 2020 an investigation into the death of Leslie Horsfield was commenced. The investigation concluded at the end of the inquest on 29 April 2021, I recorded a conclusion of accidental death. The cause of death 1a) Asphyxiation b) Blockage of airways by vomited stomach contents 2) Pneumonia, Chronic Obstructive Pulmonary Disease, Frailty.
4	**CIRCUMSTANCES OF DEATH** The deceased, who was then aged 84 years, was admitted to The Royal Oldham Hospital on 1 October 2020, with symptoms of a cough and worsening breathlessness. The Deceased was brought to A&E by paramedics and because of COVID-19 restrictions was not accompanied by a carer or family member. During the early hours of 2 October 2020, an admissions assessment was completed which included consideration of whether the Deceased had any swallowing difficulties. The assessor did not ask the Deceased whether he had experienced episodes of choking in the past and he did not volunteer that information. The evidence was that the Deceased had previously experienced a choking episode in 2018 and been assessed as having a swallowing delay. Based on the assessment undertaken on 2 October 2020, the deceased was assessed as not requiring assistance with eating or drinking, a modified diet or a swallowing assessment. On 3 October 2020, the deceased was noted to be gasping for air following which he vomited suddenly and became unresponsive. Despite prompt suctioning and medical attention, the deceased died soon after becoming unresponsive. At post mortem, the pathologist noted that food material had clogged in the left bronchus lumen. The pathologist gave evidence that the blockage of the deceased's airways by vomited stomach contents caused his death by asphyxiation. During the inquest hearing, evidence was given that had the nurse undertaking the admission assessment known about the previous choking episode she would most likely have referred the Deceased to the Speech and Language Therapy Team.
5	**CORONER'S CONCERNS** At the conclusion of the evidence, I granted the Northern Care Alliance 28 days to file further evidence to address the concern around the admissions assessment tool. That evidence was received by the court on 21 May 2021 and has been taken into account 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. The absence of any prompt in the admissions assessment tool which reminds assessors to ask patients about previous choking episodes creates a risk that relevant information is missed from the



	assessment and places the onus on the patient to volunteer information which they may not appreciate is relevant to the assessment
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 13 August 2021 I, Julie Robertson, the Assistant 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 namely:- 1. Family of Leslie Horsfield 2. 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 from. 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.
-	Date: 18.6.21 Signed: