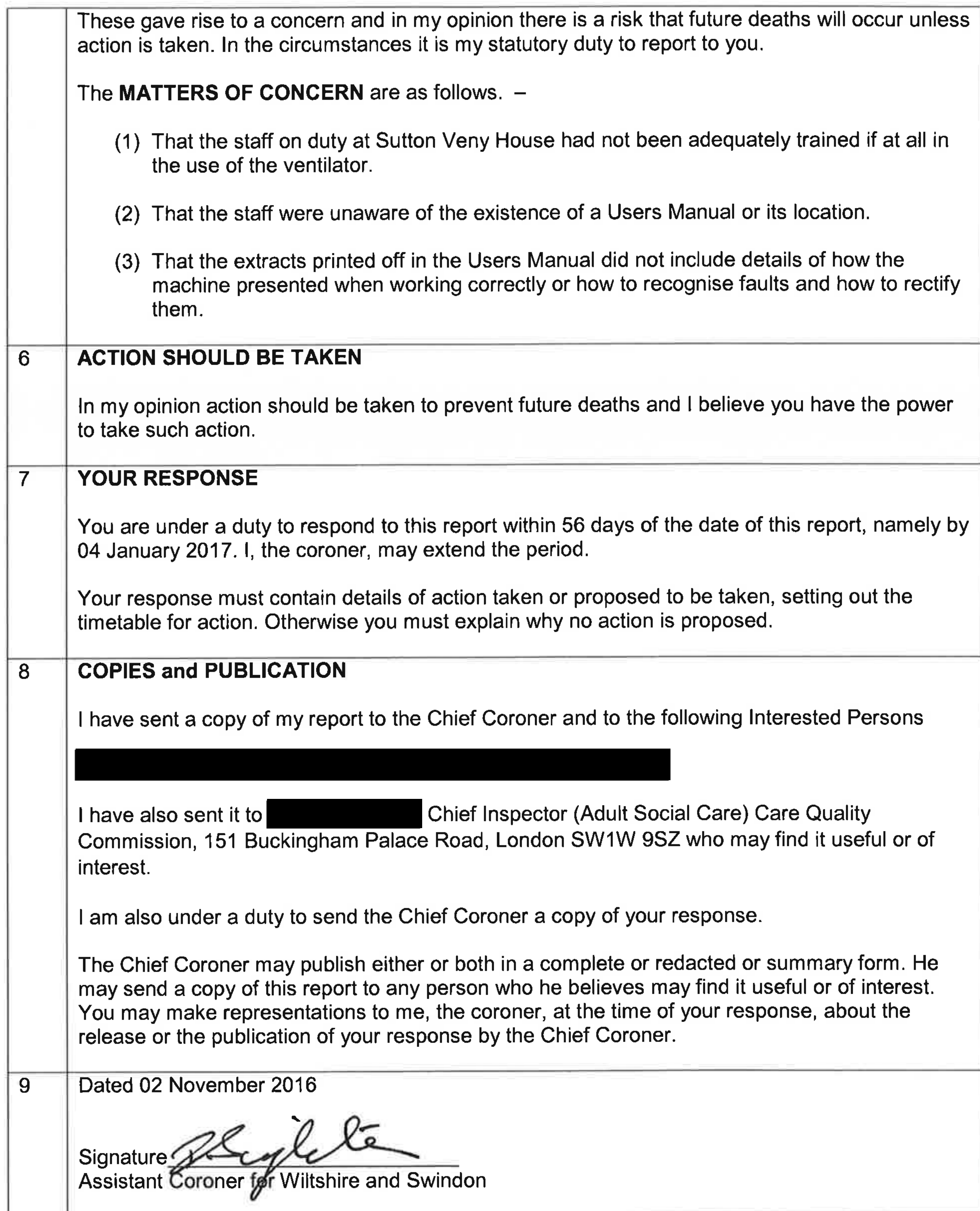
IAN SINGLETON
Assistant Coroner for Wiltshire and Swindon

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **Managing Director** **Avon Care Homes Limited** **Mendip Court** **Bath Road** **Wells** **Somerset** **BA5 3DG**
1	**CORONER** I am IAN SINGLETON, Assistant Coroner for Wiltshire and Swindon
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On the 24 June 2015 an investigation was commenced into the death of William Edward Marson aged 80. The investigation concluded at the end of the Inquest on 27 October 2016 having heard evidence on 21 September 2016 and 27 October 2016. The conclusion of the Inquest was a narrative.
4	**CIRCUMSTANCES OF THE DEATH** On the 18 June 2015 William was a resident at Sutton Veny House, Sutton Veny, Warminster Wiltshire with a history of breathing difficulties, assisted by a ventilator, but exacerbated by anxiety. During the evening when a nursing sister and 2 carers were on duty, William came to believe, incorrectly as I found, that the ventilator was not working, leading to anxiety which intensified the breathing difficulties. The Post Mortem confirmed that the medical cause of death was 1a) Ischaemic heart disease, aortic stenosis and motor neurone disease.
5	**CORONER'S CONCERNS** During the course of the Inquest, evidence was heard from several witnesses as to the fact that no formal training on the correct use of the ventilator had been given to all members of staff. As a result there was no understanding of how the ventilator presented when it was working correctly, or as to the identification of any issues which would indicate that it was not working correctly and how they might be resolved. Although a copy of the Users Manual, for the ventilator had been printed off (in part) and placed in William's room, its existence and location were unknown to the sister or carers on duty. In any event I found that the extracts that had been printed off, would not have assisted in diagnosing that in fact the machine was functioning correctly, which may have reduced Williams anxiety, had that been made known to him.



These gave rise to a concern and 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) That the staff on duty at Sutton Veny House had not been adequately trained if at all in the use of the ventilator.

(2) That the staff were unaware of the existence of a Users Manual or its location.

(3) That the extracts printed off in the Users Manual did not include details of how the machine presented when working correctly or how to recognise faults and how to rectify them.

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 04 January 2017. 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

I have also sent it to Chief Inspector (Adult Social Care) Care Quality Commission, 151 Buckingham Palace Road, London SW1W 9SZ who may find it useful or of interest.

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 02 November 2016

Signature
Assistant Coroner for Wiltshire and Swindon

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