REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Chief Executive of the Care Quality Commission (CQC); The Minister of State for Social Care
1	CORONER I am Alison Mutch, Senior Coroner, for the Coroner Area of Greater Manchester South
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 22nd January 2019 I commenced an investigation into the death of Mary Brady. The investigation concluded on the 26th February 2020 and the conclusion was one of **Narrative: Died from the complications of obtaining and ingesting latex gloves whilst unsupervised contributed to by neglect.** The medical cause of death was **1a) Foreign body airway obstruction; II) Dementia**
4	CIRCUMSTANCES OF THE DEATH Mary Brady moved to reside at Balmoral Care Home on 26th February 2019 because her lack of cognitive function due to vascular dementia meant that her family could no longer care for her. The initial placement was to be respite care but after a short time it was agreed long term care was required. After her admission to the care home Mary Brady was observed on three separate occasions to put non-food items into her mouth and had to be stopped. She lacked the necessary cognitive function to distinguish items. Her care plan was not adjusted to reflect these events. No choking risk assessment was carried out and no steps were taken to alert other staff members or highlight the risk.

	At the home, staff using latex gloves were required to dispose of them immediately after use in a secure sluice area. There were waste baskets in the communal areas but these were for items such as sweet wrappers. The waste baskets could be easily accessed by residents. Episodes of used gloves being deposited in the waste baskets had occurred previously but not escalated to senior managers although this breached the home PPE policy. On 10th March 2019 Mary Brady was found in the communal area at about 10.15pm. She was seated in the chair where she had been left unobserved and she was unresponsive. Paramedics attended and began to treat her. Whilst seeking to intubate her a paramedic extracted from Mary Brady's airway a used pair of latex gloves. Attempts continued to try to assist Mary Brady and she was transferred to Tameside General Hospital. She died at Tameside General Hospital shortly after midnight on 11th March 2019. Post-mortem examinations concluded her death was due to the presence of the latex gloves in her airway. Police investigating the circumstances of her death confirmed the gloves were from the home and had not been disposed of in accordance with the home's policy. Five further pairs of gloves were retrieved from the same basket from which, on the balance of probabilities, Mary Brady took the gloves.
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. – 1. The inquest heard that the home at the time of Mrs Brady's death, in common with many similar establishments had open waste paper baskets in the communal areas. Residents with dementia were left unsupervised in these areas and there was always a risk that they might access material from these waste baskets. In this case the gloves should not have been in the bin at all but there were other items in there which could have presented a choking hazard. The home had since removed all open wastebaskets from communal areas to avoid the risk. The inquest was told that similar baskets were common in care homes nationally. 2. The gloves were clinical waste and had been disposed of other than in the clinical waste bin in the secure area. The inquest heard that there had been previous instances of used gloves being found in the waste baskets. However the issue had not been escalated to senior managers and no steps had been taken to avoid the issue reoccurring.

	3. Mrs Brady had been seen putting foreign non-food items in her mouth by staff. These instances had not been appropriately documented and risk assessed. The level of risk she presented was not fully understood as a result and her care plan was not updated.
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 19th June 2020. 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 namely [redacted] husband of the deceased**,** 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	 **Alison Mutch OBE** **HM Senior Coroner** **24.04.2020**