Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Secretary of State for the Department of Health and Social Care, Mr S Barclay**
1	**CORONER** I am Kate AINGE, Assistant Coroner for the coroner area of Liverpool and Wirral
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 07 January 2021 I commenced an investigation into the death of Matthew Harter DALE aged 43. The investigation concluded at the end of the inquest on 25 January 2023. The conclusion of the inquest was that: Matthew was a 43 year old male with multifaceted and complex needs. He had significant learning disabilities, autism, visual impairment and bi-polar affective disorder. Matthew lacked capacity to make decisions for himself and was the subject of DOL (deprivation of liberty) safeguards. From an early age Matthew had a propensity to place non-food items into his mouth which presented as a choking risk, these risks continued throughout adulthood but were cyclical in presentation. Matthew resided in sheltered accommodation from 2008 which was deemed no longer able to meet his needs due to an escalation in behaviours which included in part, ingestion of non-food items on 4 separate occasions in short succession in 2010. In February 2011 Matthew moved to Vancouver House. Warrington borough council were the commissioning body for Matthews care and placement until September 2018 when he became eligible for Continuous Health Care funding and the Integrated care board took over that role. Matthew was known to Vancouver House managers on his transition of care to Vancouver House as posing a risk of ingesting non-food items with review in September 2011 noting that Matthew had settled in his placement and the risks associated with that were significantly reduced. Vancouver House changed ownership and with that a change of managers who at the time of Matthews death were not aware of any risks of Matthew ingesting non-food due to no ongoing identification of such risk or assessment of it since November 2011. There were no further incidents of Matthew ingesting non-food items from 2011 until 2020. As part of Matthews multifaceted and complex care plan, there was a system of reviewing Matthews care provision and a protocol for escalation of concerns around safeguarding or meeting his care needs to the agencies and professionals involved in his care. Regular and statutory reviews of Matthews care provision and placement were undertaken. No concerns were raised about risks to Matthew of the ingestion of non-food items or the provision of his care needs. There was a clear misunderstanding between commissioning authorities about Matthew's care needs and the funding and provision of care, commissioners understanding Matthew requiring constant supervision with a provision for 1:1 care 8am-8pm and ongoing waking hours supervision outside of those hours as part of the funding package. The reality was Matthew was provided with 1:1 care 8am-8pm and after that time 1:1 care when eating and hourly observations thereafter that being the assumed regime of care by Vancouver House. On the 15/12/2020 and 26/12/2020 Matthew was noted to have accessed his incontinence pad and had on at least one occasion prior to death ingested part of it. Whilst some staff had an awareness of Matthews risk to put non-food items in his mouth, others did not. Whilst

	recorded in Matthews daily notes, these concerns were not properly escalated to senior management and this provided a missed opportunity for Matthew to have increased supervision levels on an urgent basis and until a multidisciplinary team meeting could be confirmed to reassess and consider his needs. Had the incidents on the 15 and 26 December have been properly escalated, Matthew would have been on 15 minute observations, he was in fact on hourly observations and when unsupervised Matthew placed a piece of his incontinence in his mouth and swallowed it. As a result, the piece of pad expanded with the saliva and became trapped in his airway. Staff at the home staff engaged backslaps which failed to dislodge the item in question, Matthew was then incontinent of faeces and concerns were turned to attending to his personal needs rather than the serious choking risk and Matthew was taken to his room during which no further attempts were made to dislodge the choking item until his personal care needs had been met. Thereafter abdominal thrusts were noted to be given but ineffective in part due to difficulties undertaking the manoeuvre due to Matthews size and also due it being unlikely that such actions would have in any event dislodged the item. Emergency services were contacted and upon Matthew becoming unconscious CPR was commenced, taken over by paramedics upon arrival. Paramedics were able to remove the piece of pad from Matthews throat by forceps. Matthew died from placing the piece of pad in his mouth during a period in which he was not supervised and in part contributed to by missed opportunity to increase supervision to meet Matthews identified needs.
4	**CIRCUMSTANCES OF THE DEATH** Misadventure in part contributed to by a missed opportunity to increase supervision to meet Matthews needs
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) It became clear in the inquest that the commission, funding, assessment and provision of care needs is a complex process involving, particularly as in Matthews case, where there are multiple agencies involved due to his own complex and multifaceted needs. In this case it has been established that there was a confusion over the care in how it was funded and expected to be provided, compared to that which was understood to be funded and actually provided on the ground to Matthew. The confusion appears to have arisen over the understanding of a number of care terms and the use of them which has resulted in 2 commissioning agencies and an agency providing the care having differing views about Matthews care and that which should have been in place and that which was in place.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 March 23, 2023. 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 who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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: 26/01/2023**  **Kate AINGE** **Assistant Coroner for** **Liverpool and Wirral**