STOCKPORT SAFEGUARDING ADULT BOARD

SAFEGUARDING ADULT REVIEW CONCERNING

Mrs Grant

OVERVIEW REPORT

STOCKPORT ADULT SAFEGAUARDING BOARD

January 2019

post HM Coroner Inquest

Independent Chair: David Hunter

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1. INTRODUCTION

1.1 This review is about Mrs Grant[1]. She died on 28 September 2017, in Cherry Tree Nursing Home, Stockport aged 93 years. She had been a resident there since 29 March 2017, when she was discharged from hospital.

1.2 Mrs Grant had dementia and was frail. She had a DNACPR[2] [do not attempt cardio pulmonary resuscitation] in place. Her health had deteriorated in the weeks before her death and she needed assistance to eat. On the day she died, Mrs Grant was in her room at the home and was being fed by a care assistant. They noticed Mrs Grant was choking and having difficulty breathing. The care assistant alerted other staff who then attended to Mrs Grant and an ambulance was called.

1.3 On arrival, a paramedic from North West Ambulance Service [NWAS] found Mrs Grant was struggling to breath. While being treated, Mrs Grant went into respiratory arrest. The NWAS paramedic sought immediate advice by radio from an advanced paramedic. A decision was made not to commence cardio pulmonary resuscitation based on the DNACPR that was in place.

1.4 Greater Manchester Police [GMP] were informed, and an investigation was undertaken. A post mortem examination established the condition that led directly to Mrs Grant's death was 1a hypoxia[3]. The intermediate cause of her death was 1b aspiration of food[4]. The underlying cause of her death was 1c Ischaemic heart disease and vascular dementia. The investigation by GMP found no evidence of crime or direct third-party involvement in Mrs Grant's death.

1.5 Stockport Safeguarding Adults Board, in line with their statutory obligations[5], reviewed the death of Mrs Grant and commissioned this Safeguarding Adults Review [SAR] report. The terms of reference are set out within section sections 2.5 and 2.6 post. The SAR concludes there is learning for some agencies who were concerned with Mrs Grant's care in the period before, and in her treatment on the day she died. This learning is set out within section 6 of this report.

1.6 HM Coroner has held an inquest into Mrs Grant's death.

1.7 The Stockport Safeguarding Adult Review Panel wish to extend their condolences to Mrs Grant's son and family on her loss.

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[1] A pseudonym which has been selected in conjunction with the family.
[2] See appendix C.
[3] Hypoxia is a deficiency of oxygen reaching the tissues of the body.
[4] Aspiration of food simply means that the food entered the windpipe instead of the oesophagus which is a long tube that connects the mouth to the stomach.
[5] S44 Care Act 2014-see section 2.1 post.

2. ESTABLISHING THE ADULT SAFEGUARDING REVIEW

2.1 Decision Making

2.1.1 The Care Act 2014[6] gave new responsibilities to local authorities and Safeguarding Adult Boards [SAB]. Section 44 of that Act[7] requires SAB's to arrange for a review of a case when certain criteria are met. These criteria appear in Appendix A.

2.1.2 On 28 September 2017, GMP raised a safeguarding adults concern with Stockport Social Services. The following day, Stockport Safeguarding Adult Service convened a strategy meeting to review the circumstances of Mrs Grant's death.

2.1.3 Following a further strategy meeting and case conferences, a recommendation was made to the chair of the Stockport Safeguarding Adult Board that the criteria had been met for a Safeguarding Adult Review [SAR] and should be undertaken. The Chair of Stockport Safeguarding Adult Board [SSAB] agreed and arrangements were made to appoint an independent chair.[8]

2.2 Safeguarding Adult Review Panel

2.2.1 David Hunter was appointed as the Independent Chair and author on 16 May 2018. He is an independent practitioner who has experience of chairing and writing multi-agency reviews. He has never been employed by any of the agencies involved with this adult serious case review and was judged to have the necessary experience and skills. He was supported in the task by Paul Cheeseman, also an independent practitioner who brings the same experience and who wrote this report.

2.2.2 The first of four panel meetings were held on 11 June 2018. The panel established key lines of enquiry and asked agencies for information about their involvement in the case. This information was discussed at subsequent meetings at which the learning was refined, and recommendations developed.

2.3 Panel Membership

2.2.3 The panel comprised of representatives from agencies involved in the care and treatment of Mrs Grant and the investigation into her death. A full list of panel members is provided at Appendix B.

2.4 Information provided to the Review

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[6] Enacted 1st April 2015

[7] The specific requirements placed upon a Safeguarding Board by S44 of the Care Act 2014 are set out in Appendix A.

[8] An earlier Section 42 Care Act Enquiry [Enquiry by Local Authority] was not concluded because of difficulties obtaining information from some agencies.

2.4.1 The following agencies provided the panel with Individual Management Reviews [IMR] that outlined their involvement in these events;

- Cherry Tree House Nursing Home;
- NHS Stockport Clinical Commissioning Group;
- Stockport Metropolitan Borough Council Adult Social Care;
- North West Ambulance Service [NWAS];
- Greater Manchester Police [GMP].

2.4.2 The following people were seen by the SAR Chair and Author;

- General Practitioner 2 [GP2];
- Director of Operations for L & M Healthcare [Operators of Cherry Tree Nursing Home].

2.4.3 The care plan records relating to Mrs Grant are retained by HM Coroner in connection with an inquest into her death. The SAR asked HM Coroner for permission to view inspect the documents at her office in Stockport. HM Coroner agreed to this request and the SAR Chair and Author visited inspected the documents on 6 September 2018. HM Coroner also provided some other materials.

2.5 Purpose of a Safeguarding Adult Review

2.5.1 Section 44 (5) of the Care Act 2014 specifies:

Each member of the Safeguarding Adult Board must co-operate in and contribute to the carrying out of a review under this section with a view to—

(a) Identifying the lessons to be learnt from the adult's case, and

(b) Applying those lessons to future cases.

2.6 Terms of Reference

2.6.1 Stockport Safeguarding Adult Review Panel identified the following general and specific terms. The analysis of these lines will be addressed in Section 5 of the report.

General

The purpose of an adult serious case review is neither to investigate nor to apportion blame. It is to:

- Establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard vulnerable adults;

- Review the effectiveness of procedures of both multi-agency and individual organisations;

- Inform and improve local inter-agency practice;

- Improve practice by acting on learning and developing best practice;

- Prepare or commission an overview report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future actions.

Key Lines of Enquiry

1. To identify what 'do not attempt resuscitation CPR' [DNA CPR] was used by the Nursing Home where Mrs Grant was resident and whether it complied with the national DNR policy.

2. To identify how the relevant policies in relation to DNACPR were applied by those responsible for Mrs Grant's care.[9]

3. To identify the operating policy and maintenance record of the Nursing Home's suction machines including the training given to staff in their operation.

4. To identify what training, including: dietary, basic life support and first aid, employees of the Nursing Home and agency staff working in the Nursing Home underwent to enable the effective discharge of their duties.

5. To identify whether North West Ambulance Service staff who attended the Nursing Home at the time of Mrs Grant's death had a full complement of equipment to deal with Mrs Grant's needs.

6. To identify whether there was continuity of any DNAR status attached to Mrs Grant when she moved from Wythenshawe Hospital to the Nursing Home.

2.7 Period under Review

2.7.1 3 September 2015 to 28 September 2017.

2.8 Other Processes

2.8.1 Greater Manchester Police [GMP] attended at Cherry Tree House after Mrs Grant's death. An experienced Detective Inspector carried out an investigation and concluded there was no evidence of crime[10] or direct third-

[9] This key line also looked at the Mental Capacity Act aspects of the DNA CPR

[10] It is an offence under S21 of the Criminal Justice and Courts Act 2015 if an individual who has the care of another individual by virtue of being part of a care providers arrangements ill-treats or wilfully neglects that other individual.

party involvement in Mrs Grant's death. There are no suspicious circumstances and homicide has been ruled out.

2.8.2 HM Coroner has held an inquest into the death of Mrs Grant which took place after the work of the SAR has been completed. The SAR panel is grateful to HM Coroner who kindly granted the SAR review team access to some relevant statements and documents.

2.8.3 In response to the death of Mrs Grant, the Care Quality Commission [CQC] conducted a focussed inspection into the domains 'Effective' and 'Well led' to ensure service users in Cherry Tree House were safe, and that care and support provided to people identified as being at risk of choking was safe [see section 3.2 post]. CQC continue to conduct enquiries in relation to the death of Mrs Grant although they are not currently in a position to determine if any further action will be taken in relation to her death.

2.8.4 In view of the fact that a Safeguarding Adult Review (SAR) was commissioned [see paragraph 2.1.1 et al] a decision was made that the S42[11] safeguarding investigation should cease as the SAR would now cover this remit.

2.9 Family's Comments

2.9.1 The Chair of the SAR contacted Mrs Grant's son by e mail. He provided information about his mother which is included at paragraphs 3.1.1 and 3.1.2. He said he would like to see a copy of the SAR report. He also provided the following tribute to his mother.

"Mum lived through the war and lost friends, including her fiancé. She liked tennis and it was at the Gatley Tennis Club she met my father who had been in the Royal Navy. Dad had had a 'very bad war' in that he had seen a lot of death and this caused him to have what today we would call 'severe PTSD'. In 1974, he was admitted to Cheadle Royal Mental Hospital where he stayed for over six months. Mum was dedicated to helping him recover and protecting me from understanding how ill he really was. She gave a lot and the war certainly cost her although from her demeanour you would never know. Mum was always happy, she enjoyed people (and hated cooking). She was a devoted mother and taught me respect for human life and others. She was 'spiritual' and a regular churchgoer. She attended St Andrews

[11] S42 of the Care Act 2014 applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)—
(a)has needs for care and support (whether or not the authority is meeting any of those needs),
(b)is experiencing, or is at risk of, abuse or neglect, and
(c)as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.
The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case (whether under this Part or otherwise) and, if so, what and by whom.

Church in Cheadle Hulme every week until her dementia caused her to be admitted to a nursing home. Mum had a fear of going into a nursing home and confided that she would prefer to ‘pass’. She had no fear of death as she had spoken to her father after he ‘passed’ in 1981, and had had other ‘spiritual’ experiences. Mums passing was a release, I know she is happy, she has told me. She came to me a few days after her death and told me what she wanted for the funeral, including, “No flowers, people can send flowers to someone they love with the card saying, ‘In Memory of Joan’”, plus other instructions. This simple statement is now an option at the undertakers who had “never had this requested before’. It really sums her up. Mum would not want any repercussions over the manner of her passing”.

3. BACKGROUND

3.1 Mrs Grant - Her Family's Perspective

3.1.1 Mrs Grant was born in Gatley, a suburb of Manchester, in 1923 and was one of two children. Her sister died in 2012. Mrs Grant was 22 when the Second World War broke out and her father was enlisted. Her then fiancé was killed in 1944.

3.1.2 Mrs Grant married in 1950 and had one child, a son. Her husband died in 1997 and Mrs Grant insisted on "not being a burden" and remaining in her home. She lived in Cheadle Hulme from when she married only moving once in 1953.

3.2 Mrs Grant's relevant medical history including DNACPR

3.2.1 Mrs Grant had a past medical history which included Cervical cancer [1978], Hypertension [2001], Vascular dementia [2008], Chronic Kidney Disease [CKD3] [2011], Cerebral meningioma [2014] and Deep Vein Thrombosis [DVT] [2016].

3.2.2 From July 2015, Mrs Grant lived at a Nursing Home in Cheadle. She was registered with a local GP practice and seen by the same GP [GP1] on a fairly regular basis. He seemed to know her quite well and could identify changes in her wellbeing – for example he referred to her having "lost some of her usual spark".

3.2.3 Mrs Grant was frail, mostly bedbound and had very poor oral intake at times. On 28 April 2016, GP1 suggested having a discussion with Mrs Grant's son about implementing a DNACPR form. The IMR author has not been able to establish what, if any, conversations took place as there does not appear to be any documentation in the records. However, it appears a DNACPR was put in place at some stage, and remained in place, at least until her admission to Wythenshawe Hospital with a deep vein thrombosis on 12 June 2016.

3.2.4 Prior to this admission, a decision had seemingly been made by GP1 that investigation of her leg swelling would not be in her best interests. It was noted that her son was abroad and so was not contactable to discuss this. There is no evidence of a capacity assessment[12] at this time, nor was consideration given as to whether to involve an Independent Mental Capacity Advocate (IMCA)[13].

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[12] See Appendix C which summarises the salient issues in relation to mental capacity.

[13] IMCAs were introduced following the Mental Capacity Act 2005. They are people who act as a legal safeguard for those who lack the capacity to make specific important decisions: including making decisions about where they live and about serious medical treatment options. IMCAs are mainly instructed to represent people where there is no one independent of services, such as a family member or friend, who is able to represent the person.

3.2.5 On 31 January 2017, while in the hospital, Mrs Grant fell from her wheelchair and sustained a fractured femur. The CCG IMR author notes that Mrs Grant's mobility prior to, and post this event, was unchanged and does not feel that her fall or subsequent operation in relation to her condition had a significant impact on her life expectancy nor her cause of death.

3.2.6 On 28 March 2017, Mrs Grant was discharged from hospital and moved into Cherry Tree Nursing Home. She was then registered with a local GP surgery near that home and became a patient of GP2. The IMR author recognises the good practice of the surgery in collating all the relevant documents in respect of Mrs Grant's care. This included details of an earlier capacity assessment. Collating this documentation allowed the new surgery to have a full picture of Mrs Grant's past issues to help guide her future care.

3.2.7 L & M Health Care [the operators of Cherry Tree House] state that Mrs Grant needed 24-hour nursing care in one of their units [Romiley Unit]. She was immobile and nursed on a high-risk air wave mattress and repositioned 2-3 hourly during the day and every 4 hours at night. Two staff were required at all times. Although a falls risk assessment identified she was at low risk of falls she was at high risk of fracture. Mrs Grant did not have any falls while at Cherry Tree House.

3.2.8 Cherry Tree House told the panel, Mrs Grant was at high risk of weight loss and required full support with meals and fluids. Assistance was required at meal times from 1 member of staff. Mrs Grant preferred softer food because of the absence of her teeth. The panel were told that a choking risk assessment was undertaken on 6 July 2017. The risk assessment uses a numerical score and there are three bands of risk. Low risk is from 0-24, Medium risk is from 25-49 and High risk is 50+. Mrs Grant was assessed as 24 which meant she was at low risk of choking.

3.2.9 During the inquest[14] held into Mrs Grant's death before HM Coroner for South Manchester it emerged that the choking assessment score had been added incorrectly and should have been 36. The review panel asked L & M Health Care to look into this issue. The Director of Operations reviewed the Choking Risk Assessment completed in respect of Mrs Grant. The Director found that, while there had been an error in adding up the score there was also an error in the way in which two areas of the assessment had been scored. Question 8 asked if the resident has severe and enduring mental health problems. This had been answered in the affirmative giving a score of 4. Question 9 asked if the resident is confused/disorientated. This had also been answered in the affirmative scoring 4. The Director of Operations felt Mrs Grant's mental health issues were sufficiently addressed in Question 9. By also answering Question 8 in the affirmative the assessor had effectively

[14] The inquest was held after the Safeguarding Adult Review had been received and approved by Stockport Safeguarding Adult Board. HM Coroner highlighted two issues that she felt the review should consider these were the choking assessment and Mrs Grant's weight. The review panel reconvened to consider these matters and issued this revised report.

double counted and consequently the score from both of these questions should have been 4 rather than 8.

3.2.10 There was also an error in Question 28 which asked if Mrs Grant ate safely with dentures/without dentures/without teeth. The answer recorded was 'No' giving a score of 8. In fact there were no previous recorded incidents which would evidence that Mrs Grant had not eaten safely. Hence the answer to Question 28 should have been 'Yes' which would have negated the score of 8. When these two corrections are factored in, it brings the total score to 24. Hence, while the original assessment had been incorrectly added up, the corrected score still meant that Mrs Grant was at low risk of choking.

3.2.11 There is no reference within the low score banding for the need to refer the subject of the assessment to a SALT when they fall into this category. The advice within the medium risk banding is conditional in that 'Consideration should be given to referral'. As Mrs Grant was originally assessed as at low risk, then no referral to a SALT was made and this was in line with the risk assessment banding of low. The Director commented that there are many residents with a medium choke risk who have additional support measures in place. Some may have been seen by a SALT therapist and still be on a normal diet and fluids. The Director said it would be difficult for her to speculate on whether this would have been the with Mrs Grant.

3.2.12 The choking risk assessment form in use by Cherry Tree House states that the risk assessment should be updated a minimum of monthly. It does not appear there to the panel this had been the case in respect of Mrs Grant[15]. The panel has not been able to establish why the choking risk assessment was not repeated every month for Mrs Grant.

3.2.13 In relation to her diet and the meal she was eating when she was taken ill and died, the panel asked the Director if this was appropriate. Mrs Grant was recorded as eating a meal of beef stroganoff at this time. The Director said Mrs Grant had no dentures and this was recorded in her care plan. She therefore preferred a softer diet. Her original discharge letter into the Home from Hospital also specified this. The Director told the panel beef stroganoff was a soft meal with sauce and, with Mrs Grant's preference for a soft option diet, this meal would have been appropriate in line with Texture E diet and the national food descriptors[16].

3.2.14 A second issue raised during the inquest into Mrs Grant's death related to her MUST scores of between two and three and the fact that a referral was not made to the community dieticians. MUST is the Malnutrition Universal Screening Tool published by the British Association for Parenteral and Enteral Nutrition [BAPEN]. It is a five-step screening tool to identify adults,

[15] The panel noted that, immediately following the death of Mrs Grant, Cherry Tree House immediately undertook a review of the choking risk assessment process within its premises.

[16] The national food descriptor specifically includes well cooked rice within Texture E diet.

who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan. It is for use in hospitals, community and other care settings and can be used by all care workers. Following completion of a five-step process, patients are categorised as falling into one of three risk bands of malnutrition; score of 0= Low risk, score 1=Medium risk, score 2 or more=High risk.

3.2.15 Mrs Grant was weighed on the 28 March 2017. Her weight of 41.8kg and Body Mass Index [BMI] of 18 meant that she was recorded as 2 within the MUST risk banding. However, there was no previous recorded weight on the pre-admission or transfer sheet to indicate loss. Mrs Grant was weighed on ten further occasions between then and her death. On all occasions, she fell within the MUST high-risk band as she had a score of 2 or higher. The following is a record of her weight on these occasions;

Date	**Weight**
28.03.17	41.8kg
07.04.17	42.4kg
07.05.17	43.6kg
06.06.17	40.4kg
06.07.17	40.9kg
20.07.17	43.8kg
06.08.17	44.4kg
15.08.17	42.8kg
06.09.17	41.8kg
19.09.17	40.5kg
21.09.17	40.3kg

3.2.16 Management guidelines within MUST indicate that patients within the high-risk banding should be treated, unless detrimental or no benefit is expected from nutritional support e.g. imminent death. Treatment includes the following;

- Refer to dietitian, Nutritional Support Team or implement local policy;
- Set goals, improve and increase overall nutritional intake;
- Monitor and review care plan Hospital – weekly Care Home – monthly Community – monthly

3.2.17 Cherry Tree House say that a referral to a dietician was not made as staff took advice from GP2. The panel noted that the MUST tool does not make referral to a dietitian mandatory and is only one of three possible options [first bullet point 3.2.16] the others being nutritional support team or implementation of a local policy. It emerged during the inquest that GP2 has a local weight loss

protocol for nursing home residents although Cherry Tree House did not use it. The following is extracted from that protocol.

Introduction

'This protocol aims to help nursing staff at the home, in partnership with the patient's GP, to make pragmatic decisions with regards to residents with persistent weight loss. Many patients of advancing age and/or dementia will naturally lose weight which is an unfortunate but ***expected*** progression of their condition. A blanket rule to supplement feeds with energy drinks is not appropriate in all situations as there is no evidence it prolongs life for all, particularly in cases of advancing dementia. As a minimum, the GP should be informed if patients are persistently losing weight. Although there is no official definition of weight loss, thresholds are given below to help nursing staff and the GP. Nursing staff are welcome to discuss with the GP if residents don't fit the thresholds below but advice is needed.

PROCESS

The GP should be informed, routinely, by adding the patient to the ward round list if:

Weight loss of >= 10% which occurs over a period of at least 2 months.

Note: Weight loss does not necessitate an 'urgent' same day discussion with the GP'

3.2.18 Using the weights recorded within paragraph 3.2.15, Mrs Grant did not meet the criteria set out within the local weight loss protocol used by GP2. The panel has been provided by HM Coroner's Officer with copies of three relevant documents. The first of these is titled 'Nutrition Extra'. It is dated 21 July 2017 and has been completed in handwriting by a health care assistant. There is reference within the document to Mrs Grant being at high risk of weight loss. The document contains details of a plan to address Mrs Grant's weight loss that includes the regular offer of finger foods and high calorie smoothies. The document was reviewed on 6 August 2017 and a note added stating that Mrs Grant like smoothies. It was next due for review on 6 September 2017. There is no record within the document in relation to a referral to a dietitian or the GP.

3.2.19 The second document is titled 'Care Plan: Weight Loss. It is dated 26 July 2017 and handwritten. Mrs Grant is recorded as being at medium risk of weight loss. There is a similar plan to that within the 'Nutrition Extra' document in respect of supporting Mrs Grant. The document was reviewed on 26 August 2017, and a note added stating that Mrs Grant had been 'encouraged as much as possible without force'. Like the other document it was next due for review on 6 September 2017, and there is also no record within it in relation to a referral to a dietitian or the GP.

3.2.20 The third relevant document provided by HM Coroner's Officer is titled 'Record of Professional Contact'. The document is handwritten and contains five entries, four of which relate to contact with GP2, and one entry relates to contact with a pharmacy. The only reference to Mrs Grant's weight loss is an entry on 7 September 2017, from a health care assistant which includes the following;

'Also explained about weight loss and loss of appetite. Dr said to monitor and encourage as much as can'

3.2.21 The panel has carefully considered this additional information that emerged following the inquest into Mrs Grant and has made an addendum to its conclusions that are included within paragraphs 8.20 to 8.25.

3.2.22 GP2's first, and only, visit to Mrs Grant at Cherry Tree House was on 24 April 2017. It appears that during this assessment a discussion regarding DNACPR was had with staff. The Cherry Tree House notes from that visit state "no capacity" indicating that an assessment had taken place. However, there are no specific details as to why Mrs Grant was felt to lack capacity[17]. The notes suggest that GP2 would have a discussion at some future time with Mrs Grant's next of kin, although that did not take place.

3.2.23 On 7 September 2017, GP2 discussed Mrs Grant's condition by telephone with staff from Cherry Tree House. GP2 has an arrangement with Cherry Tree House for conducting telephone 'virtual ward rounds' during which staff from the home will raise and discuss any health issues or concerns they have with the doctor. The CCG IMR author says Mrs Grant was evidently deteriorating and further discussion was had regarding resuscitation. It was noted that her son lived abroad and that staff were in contact with him via email. GP2 asked a member of staff at Cherry Tree House to inform Mrs Grant's son that a DNACPR was being considered. At 10.22hrs on the same day, an email was sent from Cherry Tree House to Mrs Grant's son. The text of which was;

'I have been asked to contact you by GP2 regarding your mum. GP2 would like to issue a DNAR especially due to mum's age. Would you be happy [sic] for GP2 to issue this. If you have any objections could you please contact GP2 at [redacted surgery contact details]'

3.2.24 At 16.54hrs the same day, Mrs Grant's son sent an e mail containing the following relevant message;

'My mum signed such a statement when she was aware, this would be about 7 years ago at the surgery at the junction of [redacted address], I was with her. [Redacted name of previous home] were aware of this. So obviously I have no objection.....'

[17] The CCG IMR author says it is not unusual within GP records wherein consultations are a brief summary of the interactions had rather than a detailed verbatim account. More detailed documentation however would be beneficial and would evidence better compliance with the Mental Capacity Act (2005).

3.2.25 The following day a member of staff from Cherry Tree House contacted the GP surgery to advise them that Mrs Grant's son had no objections. At 10.46hrs on 8 September 2017 GP2 completed a form entitled 'Adult Unified Do Not Attempt Cardiopulmonary Resuscitation' [DNACPR][18]. The form contains three reasons for the decision and requires the issuer to identify which one of these is applicable.

3.2.26 GP2 selected option 'A' which states 'CPR is unlikely to be successful due to Dementia, Old Age'. GP2 also indicated below this that the decision had not been discussed with Mrs Grant because she lacked capacity. GP2 indicated that her son had been informed of the decision. There is a section within the form for review. GP2 indicated with an 'X' in the appropriate box that 'This is an indefinite decision'. Section 4 of the form provides for 'Who has been informed of this DNACPR decision'. GP2 indicated by a 'X' that the GP and Care Provider [nursing home] have been informed.

3.2.27 The next record held by the GP surgery was a telephone call to advise that Mrs Grant had passed away after becoming short of breath whilst eating.

3.3 Cherry Tree House

3.3.1 Cherry Tree House is located in Romiley, Stockport. Since October 2014, the Care Quality Commission [CQC] inspect care homes and award a quality rating in respect of five key questions [also known as 'domains] vis; is the service safe, effective, caring, responsive and well led? CQC describe Cherry Tree House as;

'... a purpose built three-storey care home owned by London and Manchester Healthcare (Romiley) Ltd. It provides nursing care for up to 81 people. Accommodation is provided across three units. Bramhall Unit, situated on the ground floor, and Romiley Unit, on the third floor, catered for people who needed nursing care. Marple Unit, which predominantly supported people living with dementia, was situated on the first floor. All bedrooms are single occupancy with en-suite toilet and shower facilities. The home has a secure garden and off-road parking is provided. There were 77 people living in Cherry Tree House at the time of our visit'

3.3.2 The last inspection of Cherry Tree House prior to Mrs Grant's death took place on 23 and 25 November 2016. A report was published on 29 December 2016. The home received an overall grading of 'good' with only one area ['Is the service well led?'] graded as 'requiring improvement'. In respect of that area the report[19] states;

'At the last inspection in May 2016, we rated the well-led domain as 'inadequate' as we found the management of the service was not, at that time, well-led and staff lacked clear management leadership. At this inspection we found the provider had taken action and was now meeting

[18] This form is a pre-printed standardised form use in the Unified DNACPR Policy in the North West of England NHS area [see paragraph 3.4.5].
[19] https://www.cqc.org.uk/sites/default/files/new_reports/INS2-3063066001.pdf

legal requirements. Although we saw improvement had been made, we have not rated this key question as 'good', to improve the rating to 'good' would require a longer-term track record of sustainable good practice'

3.3.3 Following Mrs Grant's death, and in response to it, CQC undertook a focussed inspection on 12 October 2017, which looked at the domains 'effective' and 'well led'. Cherry Tree House received an overall rating of 'good'. CQC identified the 'well led' domain as 'requiring improvement'. The inspector from CQC reported that service users were found to be safe and cared for and the Provider was taking action to minimise the risk of a similar incident happening again.

3.3.4 The SAR Chair and Author visited Cherry Tree House on 1 November 2018. As part of the visit, they met with the Director of Operations for L & M Healthcare. They helpfully provided important background information about the running of the home which is included within section 4 and section 5 of this report and acknowledged appropriately.

3.4 The law and policy in relation to DNACPR decisions

3.4.1 A key issue within this report concerns DNACPR and how it was applied in Mrs Grant's case. There is no specific piece of legislation in English law setting out how decisions relating to DNACPR should be approached. The British Medical Association, the Resuscitation Council [UK] and the Royal College of Nursing have issued guidance entitled 'Decisions relating to cardiopulmonary resuscitation'[20] ['the guidance'].

3.4.2 Policies and individual decisions about CPR must comply with the Human Rights Act 1998. Specifically Article 2 [the right to life], Article 3 [the right to be free from inhuman and degrading treatment], Article 8 [the right to respect for privacy and family life], Article 10 [the right to freedom of expression, which includes the right to hold opinion and to receive information] and Article 14 [the right to be free from discriminatory practice in respect of these rights]. From time to time, cases in relation to DNACPR and Human Rights are taken to the Courts who will issue judgments that will clarify matters.[21]

3.4.3 The following paragraphs are extracted from 'the guidance' on DNACPR. They appear at pages 4 and 5 of the document and are intended as an aid-memoire to highlight some of the main points arising from 'the guidance'. It is stressed within 'the guidance' that the main messages are not designed to be read in isolation from the rest of the document. Given the very serious nature of the decisions being made, readers are urged to take time to consider the whole document.

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[20] https://www.rcn.org.uk/professional-development/publications/pub-005688

[21] There is some relevant case law from the Court of Appeal in Tracy v Cambridge university hospital FT (June 2014) and Winspear v City Hospital Sunderland NHST (Nov2015) where the judge said failure to discuss DNACPR with a person without capacity or a relative was a breach of section 4(7) MCA and a violation of the procedural duty under art 8.2 ECHR.

3.4.4 Where appropriate, this SAR report will make reference to the main messages below and to extracts from 'the guidance'.

1. Considering explicitly, and whenever possible making specific anticipatory decisions about, whether or not to attempt CPR is an important part of good-quality care for any person who is approaching the end of life and/or is at risk of cardiorespiratory arrest.
2. If cardiorespiratory arrest is not predicted or reasonably foreseeable in the current circumstances or treatment episode, it is not necessary to initiate discussion about CPR with patients.
3. For many people, anticipatory decisions about CPR are best made in the wider context of advance care planning, before a crisis necessitates a hurried decision in an emergency setting.
4. Every decision about CPR must be made on the basis of a careful assessment of each individual's situation. These decisions should never be dictated by 'blanket' policies.
5. Each decision about CPR should be subject to review based on the person's individual circumstances. In the setting of an acute illness, review should be sufficiently frequent to allow a change of decision (in either direction) in response to the person's clinical progress or lack thereof. In the setting of end-of-life care for a progressive, irreversible condition there may be little or no need for review of the decision.
6. Triggers for review should include any request from the patient or those close to them, any substantial change in the patient's clinical condition or prognosis and transfer of the patient to a different location (including transfer within a healthcare establishment).
7. For a person in whom CPR may be successful, when a decision about future CPR is being considered there must be a presumption in favour of involvement of the person in the decision-making process. If she or he lacks capacity those close to them must be involved in discussions to explore the person's wishes, feelings, beliefs and values in order to reach a 'best interests' decision. It is important to ensure that they understand that (in the absence of an applicable power of attorney or court-appointed deputy or guardian) they are not the final decision-makers, but they have an important role in helping the healthcare team to make a decision that is in the patient's best interests.
8. If a patient with capacity refuses CPR, or a patient lacking capacity has a valid and applicable advance decision to refuse treatment (ADRT), specifically refusing CPR, this must be respected.
9. If the healthcare team is as certain as it can be that a person is dying as an inevitable result of underlying disease or a catastrophic health event, and CPR would not re-start the heart and breathing for a sustained period, CPR should not be attempted.

10. Even when CPR has no realistic prospect of success, there must be a presumption in favour of explaining the need and basis for a DNACPR decision to a patient, or to those close to a patient who lacks capacity. It is not necessary to obtain the consent of a patient or of those close to a patient to a decision not to attempt CPR that has no realistic prospect of success. The patient and those close to the patient do not have a right to demand treatment that is clinically inappropriate and healthcare professionals have no obligation to offer or deliver such treatment.

11. Where there is a clear clinical need for a DNACPR decision in a dying patient for whom CPR offers no realistic prospect of success, that decision should be made and explained to the patient and those close to the patient at the earliest practicable and appropriate opportunity.

12. Where a patient or those close to a patient disagree with a DNACPR decision a second opinion should be offered. Endorsement of a DNACPR decision by all members of a multidisciplinary team may avoid the need to offer a further opinion.

13. Effective communication is essential to ensure that decisions about CPR are made well and understood clearly by all those involved. There should be clear, accurate, honest and timely communication with the patient and (unless the patient has requested confidentiality) those close to the patient, including provision of information and checking their understanding of what has been explained to them. Agreeing broader goals of care with patients and those close to patients is an essential prerequisite to enabling each of them to understand decisions about CPR in context.

14. Unnecessary delay in offering discussions, explanations and information about CPR decisions can lead to misunderstanding and dissatisfaction. Delivering these communications in an inappropriate or insensitive way can also lead to dissatisfaction. A decision to delay or avoid communication of a decision to a patient must be based on that communication being likely to cause the patient physical or psychological harm. A decision to delay communication of a decision to those close to a patient without capacity must be based on that communication being either not practicable or not appropriate in the circumstances.

15. Any decision about CPR should be communicated clearly to all those involved in the patient's care.

16. It is essential that healthcare professionals, patients and those close to patients understand that a decision not to attempt CPR applies only to CPR and not to any other element of care or treatment. A DNACPR decision must not be allowed to compromise high quality delivery of any other aspect of care.

17. A DNACPR decision does not override clinical judgement in the unlikely event of a reversible cause of the person's respiratory or cardiac arrest that does not match the circumstances envisaged when that decision

was made and recorded. Examples of such reversible causes include but are not restricted to – choking, a displaced tracheal tube or a blocked tracheostomy tube.

18. Decisions about CPR must be free from any discrimination, for example in respect of a disability. A best-interests decision about CPR is unique to each person and is to be guided by the quality of future life that the person themselves would regard as acceptable or, in the case of children taken into account the views of the child and parents.

19. Clear and full documentation of decisions about CPR, the reasons for them, and the discussions that informed those decisions, is an essential part of high-quality care. This often requires documentation in the health record of detail beyond the content of a specific CPR decision form. Where such discussions are not practicable or not appropriate, the reasons for this must be documented fully.

20. A CPR decision form in itself is not legally binding. The form should be regarded as an advance clinical assessment and decision, recorded to guide immediate clinical decision-making in the event of a patient's cardiorespiratory arrest or death. The final decision regarding whether or not attempting CPR is clinically appropriate and lawful rests with the healthcare professionals responsible for the patient's immediate care at that time.

21. Use of a CPR decision form that is used, recognised and accepted across geographical and organisational boundaries is a basic recommendation and may be paper-based or electronic, subject to local agreement.

22. Recorded decisions about CPR should accompany a patient when they move from one setting to another.

23. Records of decisions about CPR must be accurate and up-to-date. Systems (whether paper-based or electronic) for recording these decisions must be reliable and responsive, in particular, to any change in the decision about CPR.

24. Where no explicit decision about CPR has been considered and recorded in advance there should be an initial presumption in favour of CPR. However, in some circumstances where there is no recorded explicit decision (for example for a person in the advanced stages of a terminal illness where death is imminent and unavoidable and CPR would not be successful) a carefully considered decision not to start inappropriate CPR should be supported.

25. Failure to make timely and appropriate decisions about CPR will leave people at risk of receiving inappropriate or unwanted attempts at CPR as they die. The resulting indignity, with no prospect of benefit, is unacceptable, especially when many would not have wanted CPR had their needs and wishes been explored.

3.4.5 In the North West NHS area a Unified DNACPR Adult Policy [henceforth referred to as the unified policy] that was adopted in 2014 and applies to all of the multidisciplinary health, social and tertiary care teams involved in patient care across the range of settings within the North West area. NWAS is a party to this document. The document is not replicated in this report. It follows the guidance and where necessary extracts from it will be referred to in this report.

3.5 Mental Capacity

3.5.1 Another relevant issue considered within this report relates to mental capacity. Mrs Grant suffered from dementia. There are several types of the condition and Dementia UK[22] describes it as;

'Dementia is an umbrella term used to describe a range of progressive neurological disorders, that is, conditions affecting the brain. There are many different types of dementia, of which Alzheimer's disease is the most common. Some people may have a combination of types of dementia. Regardless of which type is diagnosed, each person will experience their dementia in their own unique way'

3.5.2 Information provided by Mrs Grant's GP surgery indicates a diagnosis of vascular dementia was made in May 2008. Dementia UK describes vascular dementia as;

'the second most common form of dementia in the over-65 age group. It's an umbrella term for a group of conditions caused by problems with blood circulation to the brain. Causes can range from small blood clots, to blocked arteries, to burst blood vessels..... symptoms of vascular dementia can vary depending on which area of the brain has been affected. Changes in mood, behaviour, ability to perform daily activities can be affected'

3.5.3 Vascular dementia is a progressive condition, sometime progressing erratically, and eventually leads to the patient requiring significant levels of support, as was the case with Mrs Grant. Patients with dementia may lack the capacity to make decisions for themselves. In such cases the Mental Capacity Act 2005 [MCA 2005] is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment. Appendix C sets out the main points in relation to MCA 2005.

[22] www.dementiauk.org/understanding-dementia/

4. EVENTS ON 28 SEPTEMBER 2017

4.1 The following narrative chronology has been compiled from information within witness statements supplied by HM Coroner, from IMRs provided by the relevant agencies and from conversations the Chair and Author of the SAR held with relevant agencies and their staff. When it has been possible to identify a time for a key event, it is shown in bold at the head of the relevant paragraph. Some of the timings have been taken from the recollections of witnesses and as such should not be relied upon as being precise. They are included only in as much as they assist the reader to follow the chronology of events.

12.30hrs

4.2 HCA1 is a health care assistant employed by L & M and at the time worked on the Romiley suite at Cherry Tree House. She started work there about three weeks before Mrs Grant died. She knew Mrs Grant quite well and had formed a caring bond with her. It is clear from her statement that she has been significantly affected by witnessing Mrs Grant's death. Over the period she knew Mrs Grant, HCA1 noticed her appetite decreased.

4.3 On the day, and at this approximate time, HCA1 went to give Mrs Grant her lunch. This was beef stroganoff and rice. Mrs Grant was in bed, slightly on her right and in an upright position. HCA1 gave Mrs Grant one teaspoon of rice and sauce, which she swallowed. HCA1 gave her a second teaspoon of food, which Mrs Grant spat out.

4.4 HCA1 then gave Mrs Grant a third tea teaspoon of food and Mrs Grant started to cough. HCA1 sat Mrs Grant up and then hit her on the back. HCA1 says Mrs Grant started to make a 'horrible noise' and 'I could see she was losing colour'. At this point HCA1 called for help from HCA2.

12.40hrs

4.5 HCA2 has been employed at Cherry Tree House for about three and a half years. She was working in the office on the Romiley Suite with the Unit Manager who is also a registered nurse[23] [henceforth referred to as N1]. N1 had worked at the home for four weeks when these events occurred.

4.6 N1 says HCA1 came running into the office and said she thought Mrs Grant was 'choking'. All three members of staff went immediately to Mrs Grant's room. N1 says Mrs Grant was sat up in bed and her breathing was laboured. Her lips and peripheries were blue, which she says N1 indicated to her that whatever was happening to Mrs Grant could have been happening for some time.

4.7 N1's initial thoughts were that Mrs Grant may have aspirated on something, either food or vomit. She looked into Mrs Grant's throat and saw only some

[23] N1 works four days a week at Cherry Tree House. He role is split into two parts. For two days she works as a nurse and for two days in a management role. On 28 September 2017 she was working in a management role.

bubbling/phlegm, N1 says she saw ‘nothing obvious to the eye’. She asked HCA2 to fetch the suction machine. N1 went back to the office, described as being only two doors away, and telephoned telephone 999.

4.8 The recollections of staff differ at this point. HCA1 says it was she who was asked by N1 to fetch the suction machine. N1 says she asked HCA2 to fetch the machine. HCA1 says she didn’t know anything about suction machines or where they were kept and therefore had to ask another member of staff to give her the machine which she then took to Mrs Grant’s room.

4.9 The SAR panel does not feel the difference of accounts as to who fetched the machine is significant. The panel recognises that, in rapidly moving situations like this, witnesses sometimes have understandable differences in matters of detail. Whoever fetched it, the SAR panel are satisfied that within a very short period of time a suction machine was taken to Mrs Grant’s room.

12.43hrs

4.10 The SAR has been provided with a recording of the 999-call made to NWAS and from this a transcript has been prepared [See Appendix D]. The recollections of those involved vary slightly at this point. N1 says she made the initial 999 call. However, the transcript of the call indicates the initial call was made by another member of staff who, after a brief conversation with the operator, hands the call over to N1. Again the SAR panel do not believe the differences in the witnesses’ recollections are materially significant. The relevant issue is that, very quickly after Mrs Grant became ill, a 999 call was made and emergency medical aid summonsed.

4.11 Within the transcript of the call the N1 describes how Mrs Grant needed oxygen and may have choked on a tablet. The operator asks on two occasions whether Mrs Grant is breathing. N1 tells the operator that Mrs Grant is breathing, although it is laboured and ‘wet’. During the initial call the operator tells N1 four times not to slap Mrs Grant on the back and that if she starts wheezing, making funny noises or becomes unconscious to tell the operator immediately.

4.12 N1 then left the telephone to tend to Mrs Grant. HCA2 took over the call with the NWAS operator. A brief conversation then took place during which the operator obtained details about Mrs Grant. There is reference during the conversation to the possibility that Mrs Grant may have choked upon a tablet. HCA2 told the operator ‘no’ and that Mrs Grant had difficulty that morning swallowing her tablets but that on this occasion she had been assisted with her dinner and may have ‘aspirated’. HCA2 was advised by the operator not to slap Mrs Grant on the back.

4.13 N1 says that when she returned to Mrs Grant, her breathing was laboured. A suction machine [suction machine 1] had by then been brought to the room. N1 switched it on and it would not reach Mrs Grant. N1 also noticed the machine was not generating suction. She looked into Mrs Grant’s mouth and could not see any obstruction. N1 did not make any further attempts to use

suction on Mrs Grant and says she did not want to push anything further and cause more problems.

4.14 After answering the NWAS operator's brief questions, HCA2 terminated the call after asking the operator to call her back on HCA2's mobile telephone. This allowed HCA2 to leave the office, where the landline was located, and return to Mrs Grant's room where she was able to see at first hand Mrs Grant's condition and provide a commentary to the operator. This took a few seconds to achieve.

4.15 Once HCA2 resumed the call with the NWAS operator she told them that Mrs Grant was really struggling to breath and was blue. The operator told HCA2 they wanted to assess Mrs Grant's breathing and asked HCA2 to tell her every time Mrs Grant took a breath. After telling the operator once that Mrs Grant had taken a breath, HCA2 then said Mrs Grant had stopped breathing. After a few moments HCA2 told the operator Mrs Grant breathing had restarted.

4.16 The operator and HCA2 then counted Mrs Grant taking four breaths before the counting stopped. The operator then told HCA2 to let them know if anything changed. After a very short period of time HCA2 told the operator Mrs Grant had stopped breathing then very quickly HCA2 said she had started breathing again. During this second call the operator again told HCA2 not to slap Mrs Grant on the back. That made a total of five times the 'do not slap on back' advice was given.

12.47hrs

4.17 PM1 is a paramedic employed by NWAS. At this time she was working as a sole responder on a rapid response vehicle. She received a call through her mobile data terminal to go to Cherry Tree House to attend a choking incident. On their way to the call, PM1 was told the patient had stopped breathing and had then started breathing again.

4.18 HCA2 was still in contact with the operator by telephone. The transcript of the recording shows that HCA2 asked the operator if they should undertake suction on Mrs Grant. After appearing to check with someone at their end of the call, the operator told HCA2 they could not give advice on this and that HCA2 should do what they would normally do in these situations. At that point HCA2 told the operator the paramedics had arrived.

12.55hrs

4.19 PM1 arrived at Cherry Tree House and was escorted by a member of staff from the ground floor to Romiley Suite on the upper floor which she reached by lift. N1 left Mrs Grant's side briefly to meet PM1 at the entrance to the Suite. While this was happening, HCA2 remained in contact with the NWAS operator. After a few moments HCA2 told the operator that Mrs Grant had stopped breathing again. The operator advised HCA2 to carry out at an action upon Mrs Grant that involved jerking her arms up and into Mrs Grant stomach until she could breathe. The SAR panel has not been able to verify

precisely what type of manoeuvre this was, although it seems similar to the Heimlich manoeuvre.

4.20 It is not clear whether HCA2 attempted this manoeuvre before the operator asked if Mrs Grant could breathe. HCA2 said Mrs Grant was breathing 'a bit'. The operator told HCA2 to watch Mrs Grant very carefully and not to slap her on the back. The operator continued and told HCA2 that if Mrs Grant started wheezing, making funny noises or became unconscious HCA2 must tell the operator immediately.

13.00hrs

4.21 PM1 arrived at Mrs Grant's bed. HCA2 told the operator this fact and the telephone call was terminated. PM1 recorded that Mrs Grant was unresponsive, meaning she was unconscious. PM1 says Mrs Grant appeared to be gasping and had 'agonal' breathing[24]. PM1 was told Mrs Grant had 'a do not attempt resuscitation order'. It is not clear which member of staff provided that information. PM1 looked into Mrs Grant's mouth and found it appeared to be clear.

4.22 PM1 says they then asked a person they described as a nurse to lay the bed back [henceforth referred to as N2]. This was not N1, as PM1 described N1 as being the nurse who had met at the entrance to the Suite. By this time it seems there may have been several members of staff in and around Mrs Grant's room. The SAR panel do not believe these detailed differences in accounts make any significant difference to understanding the nature of the treatment Mrs Grant received.

4.23 PM1 then went to get a laryngoscope[25] from her advanced life support bag. While doing that PM1 asked N1 to get the oxygen out of her bag. PM1 noticed the oxygen tank was empty. PM1 then inserted the laryngoscope into Mrs Grant's mouth and stated she could see 'secretions'. PM1 then asked to use suction machine 1. The tubing from suction machine 1 would not reach Mrs Grant and at that point N2 told PM1 that suction machine 1 would not suck.

4.24 N2 then left the room and returned with another suction machine belonging to Cherry Tree House [henceforth referred to as suction machine 2]. N2 plugged the machine into the power supply and this machine would not suck either. PM1 asked N2 if suction machine 2 was connected correctly before leaving the room to return to collect the suction machine kept on the emergency response vehicle parked outside. While at the vehicle PM1 collected both a suction machine [suction machine 3] and a spare oxygen cylinder.

4.25 PM1 returned to Mrs Grant's side and says she used suction machine 3 to clear Mrs Grant's airway. PM1 says it looked like she was suctioning rice

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[24] Agonal breathing is the medical term for the gasping that people do when they're struggling to breathe because of cardiac arrest or other serious medical emergencies.

[25] A device that permits a clinician to look into the throat or airway of a patient.

grains. Once Mrs Grant's airway was clear it appeared to PM1 that Mrs Grant took a shallow breath so PM1 placed a none re-breathing mask over her mouth with 15 litres per minute of oxygen. Mrs Grant then stopped breathing. As PM1 knew Mrs Grant had a DNACPR in place she was not sure whether she should ventilate her. PM1 therefore contacted their clinical support hub for advice.

4.26 PM1 then had a conversation by mobile telephone with an Advanced Paramedic [AP1] from the clinical support hub. AP1 asked PM1 whether Mrs Grant had suffered respiratory arrest[26]. PM1 said Mrs Grant had and explained to AP1 that she could still feel a weak pulse on Mrs Grant's neck. AP1 asked PM1 whether the DNACPR was specific, or if it was a blanket one. PM1 explained it was a blanket one. AP1 then advised PM1 not to commence ventilations on Mrs Grant, to remove the oxygen and perform a four lead ECG[27].

13.14hrs

4.27 PM1 followed the advice of AP1 and found that Mrs Grant's heart rhythm was asystole[28] and death was diagnosed.

14.01hrs

4.28 GMP were informed by NWAS of the death of Mrs Grant and commenced an investigation. A Detective Inspector, Detective Sergeant and Police Coroner's Officer attended Cherry Tree House later that afternoon and conducted enquiries, examined the scene and the body of Mrs Grant and arranged for her removal to Stepping Hill Hospital where a post mortem was conducted.

[26] Respiratory arrest is a condition that exists at any point a patient stops breathing or is ineffectively breathing. It often occurs at the same time as cardiac arrest, but not always.
[27] An electrocardiogram (**ECG**) is a simple test that can be used to check the heart's rhythm and electrical activity. Sensors attached to the skin are used to detect the electrical signals produced by the heart each time it beats.
[28] A condition in which the heart ceases to beat

5. ANALYSIS AGAINST THE KEY LINES OF ENQUIRY

5.1 Introduction

5.1.1 Each key line is examined separately. Commentary is made using the material gathered during the SAR. This includes the family's views, discussions held by SAR members with individual practitioners and the panel's own debates. Some of the material may fit in more than one key line of enquiry and, where this happens, a 'best fit' approach has been adopted to avoid duplication.

5.2 Key Line 1

To identify what 'do not attempt resuscitation CPR' [DNACPR] was used by the Care Home where Mrs Grant was resident and whether it complied with the national DNR policy.

5.2.1 To gain an understanding of this issue the Chair and Author of the SAR met with the Operations Director for L & M Health Care [the Director]. Although the Director was at Cherry Tree House on the day Mrs Grant died she had not been directly involved in her care. She was therefore only able to comment upon the policies and procedures of L & M and was not able to provide a first-hand account as to how they were applied. All three members of staff from the home who were directly involved in Mrs Grant's care have now left the employment of L & M Health Care and therefore the SAR was not able to engage directly with them.

5.2.2 The Director explained that the issue of DNACPR is one that frequently occurs given the age and frailty of many of the residents at Cherry Tree. It is a sensitive issue and one that is always approached with care and dignity and will always involve the resident [if they have capacity] their family or representative and a doctor.

5.2.3 Pre-admission assessment and planning is undertaken for each resident before they are admitted to Cherry Tree House. When applicable, this will include reviewing any notes available from the hospital if the resident is moving from there. During this assessment a variety of issues will be considered. When the Chair and Author visited the offices of HM Coroner they inspected the records that had been completed by Cherry Tree House in respect of Mrs Grant and noted that forms in relation to per-admission assessment and planning had been completed on 21 March 2017.

5.2.4 These forms included information about Mrs Grant's mental capacity, her next of kin, and her eating and drinking preferences. It was recorded on the forms that Mrs Grant lacked capacity and that a capacity assessment had been conducted when she was a patient on the hospital ward on 1 February 2017. The form stated that Mrs Grant required an MCA assessment for complex issues and support of her family. It further stated that Mrs Grant could make simple decisions on everyday life and was offered choices.

5.2.5 The form recorded that Mrs Grant had been the subject of DOLS when resident at the previous home[29]. It also recorded that Mrs Grant liked softer food. A section under the heading 'Making decisions under the MCA 2005' contained the following entry dated 24 April 2017;

'[Mrs Grant] [sic] needs 24hr nursing care. She cannot care for herself at home. Her safety, welfare would be at risk'

The Director summed up Mrs Grant's level of understanding by saying that she could make 'anticipatory choices'. For example, if Mrs Grant was asked if she was cold, staff could hold up a cardigan and she could indicate she was cold and wanted the cardigan on by pointing at it.

5.2.6 The pre-admission assessment and planning form inspected at HM Coroner's offices did not contain any information about DNACPR. There was a reference to 'Lasting power of attorney' which contained a tick against it. However, there was no copy of this document nor did it explain the extent of that power nor who held it.

5.2.7 The Director explained that discussion about DNACPR was not something that was automatically done as part of the pre-admission process. It was something that would depend upon the individual circumstances of each resident of the home. When it was appropriate to consider DNACPR, the home discussed the issue with a doctor and the responsibility for making the decision, including the assessment of capacity, rested with the doctor.

5.2.8 If a doctor decided DNACPR was appropriate for a resident then it was the doctor's responsibility to record this on a form. The doctor then provided the home with a copy of the form[30]. This was always printed on purple paper and the purple copy retained on the residents file at the home. The purple copy of the form for Mrs Grant was retained among the documents held by HM Coroner. There is a process by which the doctor can inform NWAS that DNACPR was in place.

5.2.9 As well as being held on file, the home also recorded visibly elsewhere, within private areas accessible to staff, those residents that had an advanced DNACPR. The Director explained that the application of DNACPR always took place in accordance with the terms of the individual DNACPR form and in accordance with national policy. So, when a patient was at the end of life as the result of a pre-existing condition such as dementia and cardiac arrest occurred in circumstances anticipated within the DNACPR order, staff would not attempt resuscitation nor would they summon an ambulance.

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[29] The SAR was told an application for Deprivation of Liberty Safeguard [DOLS] had been made for Mrs Grant when she entered Cherry Tree House although it had not been authorised at the time of her death.

[30] The purple form referred to is a standard form used throughout the NHS North West area and a template for it is contained within the NHS unified policy.

5.2.10 Staff at the home would act differently in circumstances which were not anticipated, such as the case of a resident choking, which is a potentially reversible condition. In such circumstances the Director explained that DNACPR would not apply and staff would attempt to deal with the resident's condition and when necessary call an ambulance. When that arrived then the paramedic would assume responsibility for the patients care. Staff would inform them about any DNACPR that applied and the paramedic would then assume responsibility for care. Any decision to attempt CPR or not would be the decision of the paramedic and not staff employed at the home.

Findings in respect of Key Line 1

5.2.11 The SAR felt the Director at Cherry Tree House appeared to have a good understanding of DNACPR. Although the SAR has not been provided with a copy of the written policy used in the home, it appeared from the conversation with the Director that staff follow a policy that replicates the national guidance on DNACPR and the unified policy. Many of the residents at Cherry Tree House will end their lives there. The home seems to recognise the importance of considering DNACPR as part of good quality care.

5.2.12 It appears to the SAR that the home recognises the importance of advance planning before a crisis arises. They also appear to recognise the sensitivities DNACPR raises and the appropriate way in which the topic should be approached with residents and their relatives. The issue of DNACPR is inevitably very much part of the everyday business of caring for people who are reaching the end of their life in a care home. It appears to the SAR that staff at Cherry Tree House deal with the DNACPR with the appropriate level of seriousness and dignity the topic deserves.

5.2.13 In Mrs Grant's case there is a strong indication she may have made an advanced decision about DNACPR before she arrived at Cherry Tree House. However, there is no evidence the record of this decision still exists or, if it does, it ever accompanied Mrs Grant to Cherry Tree House. The SAR do not know why. It appears that Staff at the home therefore dealt appropriately with Mrs Grant as if there was no advance decision in place. Hence there was a discussion between GP2 and staff concerning DNACPR when he visited Mrs Grant on 24 April 2017.

5.2.14 Once the DNACPR order was issued by GP2 on 8 September 2017 Cherry Tree House were provided with a correctly coloured copy of the form which they retained on file. They communicated the presence of the order to staff in the home who appeared to be aware it was in place, hence HCA2 was able to brief PM1 when she arrived to treat Mrs Grant. Retention and communication of DNACPR is an important issue that is reinforced within the guidance particularly at main message 13 and elsewhere [see page 12-14 of this report]. The SAR feel that staff from Cherry Tree House demonstrated clear compliance with this element of the guidance.

5.2.15 The Director clearly understood and was able to demonstrate in conversation with the SAR Chair and Author that she, and staff at Cherry Tree House, understand that DNACPR only applies in circumstances when cardiac arrest has occurred. They also clearly recognised that 'DNACPR decision does not override clinical judgement in the unlikely event of a reversible cause of the person's respiratory or cardiac arrest that does not match the circumstances envisaged when that decision was made and recorded' [main message 17 page 14 this report].

5.2.16 The evidence that demonstrates staff could apply that knowledge was the way in which they swiftly responded when Mrs Grant began to choke on 27 September 2017. It is clear staff recognised that Mrs Grant's condition was potentially reversible and not that which was anticipated within the DNACPR. Staff made attempts to clear the blockage that was causing Mrs Grant breathing difficulties and very quickly summoned an ambulance. While waiting for that to arrive sustained attempts were made by them to treat her condition. All of this was in line with the main messages of the guidance.

5.3 Key Line 2

To identify how the relevant policies in relation to DNACPR were applied by those responsible for Mrs Grant's care.

5.3.1 Key Line 1 has already included consideration of how the relevant policy in relation to DNACPR was applied by the care home and is therefore not repeated here. The following paragraphs relate to how GP1, GP2 the NWAS operator, PM1 and AP1 applied the relevant policies applicable to them.

Actions of GP1

5.3.2 In respect of GP1 it appears a DNACPR decision may have been made at some time between 28 April 2016 and 12 June 2016. Documentation regarding the actual decision-making process and even the eventual decision was absent from the medical record. It appears consideration was given to discussing a DNACPR order with Mrs Grant's son while he was visiting the UK from abroad. It is unclear whether this conversation ever took place.

5.3.3 Around this time it also appears that a 'best interests' decision was made regarding whether to further investigate Mrs Grant's leg swelling. The CCG IMR author identified that a formal capacity assessment was not undertaken at that time. While it was noted communication with Mrs Grant's son would be challenging, there seemed to have been no consideration about whether to involve an Independent Mental Capacity Advocate (IMCA) to assist in this 'best interests' decision.

Actions of GP2

5.3.4 GP2 considered the need for DNACPR on 24 April 2017. The CCG IMR author has reviewed the records relating to this event and the decision GP2 made on 8 September to issue a DNACPR order. The Chair and Author also visited GP2 at his surgery to discuss the issues.

5.3.5 GP2 could remember little, if anything, about either event other than what was contained in his notes. The SAR felt that was reasonable given the passage of time and the numbers of patients he had since seen, in his busy sole GP practice.

5.3.6 The records indicate that GP2 conducted a capacity assessment on 24 April 2017 although the documentation of this assessment is minimal. Consideration was given to involve the family, although it is not clear whether this was done. In any event, the decision was seemingly not made at this time as there is a reference within the notes to GP2 having a discussion at 'some future time' with Mrs Grant's next of kin.

5.3.7 The SAR wondered if the reference to 'some future time' might be an indicator that it was not yet felt appropriate to issue a DNACPR order. If that was the case, the SAR felt it indicated compliance with the guidance [point 4 of the main messages page 12] that 'every decision is made on the basis of each individual's situation. These decisions should never be dictated by 'blanket' policies'.

5.3.8 When the SAR Chair and Author met with GP2 he made the point to them that he is very careful not to be pushed into making 'blanket' DNACPR decisions by nursing homes as part of the process of admitting a new resident. It appeared that GP2 correctly recognised that every DNACPR decision had to be specific to the needs of the individual.

5.3.9 Main message 6 from 'the guidance' [page 12 of this report] is that 'triggers for review [of DNACPR] should include….any substantial change in the patient's clinical condition or prognosis'. The CCG IMR author feels, and the SAR agrees, that by 7 September 2017 Mrs Grant was evidently deteriorating. She had an irreversible condition and by then was reluctant to take food and drink.

5.3.10 In conversation with the SAR Chair and Author, GP2 made the point that this is very often typical in patients like Mrs Grant. He explained the process he had for carrying out regular 'virtual ward' rounds with Cherry Tree House. These take place at pre-arranged dates and times by telephone during which staff from the home will discuss with GP2 health issues relating to residents.

5.3.11 It appears that it was during one of these 'virtual rounds' that the change in Mrs Grant's condition and the need for a DNACPR was discussed. Given the change in her condition it appears to the SAR that the timing of the decision to initiate a conversation about DNACPR was therefore appropriate and was in line with main message 6 of the guidance.

5.3.12 The CCG IMR author [himself a GP] has considered the appropriateness of the decision to issue a DNACPR order that was made by GP2 on 8 September 2017. The author says the rationale to not undertake CPR recorded on the DNACPR form was that CPR was unlikely to be successful due to Mrs Grant's age and comorbidities. The author says it is evident from the records that Mrs Grant was very frail, and also that GP2 was not the only clinician to have felt she was unsuitable for resuscitation. Therefore the decision to issues a DNACPR order would seem to be a reasonable clinical decision.

5.3.13 The guidance states "There should be… a presumption in favour of explaining the need for and reasons for the decision to the patient or to those representing a patient without capacity". GP2 had assessed Mrs Grant as lacking capacity in April 2017. There is no documentation of a further capacity assessment when GP2 made the decision to issue a DNACPR order on 8 September.

5.3.14 Capacity assessment is time and decision specific. The fact that GP2 did not record a capacity assessment on 7 or 8 September was therefore an omission. The SAR Chair and Author discussed this point with GP2 when they met with him. He explained that his rationale for not recording the decision was that he had seen Mrs Grant in April 2017. She lacked capacity then and, given that she had vascular dementia which is progressive and irreversible, it was obvious that she would lack capacity in September 2017.

5.3.15 The SAR Author and Chair discussed with GP2 whether he should at that point have considered involving an Independent Medical Advocate [IMCA] in the decision making. GP2 said that when making DNACPR decisions he always ensures there is contact with the family. GP2 maintains a detailed spreadsheet recording all DNACPR decisions and this contains contact details for family members. On this occasion the surgery had no contact details for Mrs Grant son. GP2 felt the method of contact with Mrs Grant's son that was made, by e mail by a staff member from Cherry Tree House, was therefore appropriate. GP2 was aware that Mrs Grant's son had not raised any objections to the decision GP2 was about to make.

5.3.16 Paragraph 5.20 of the unified policy is repeated in full here as it covers these circumstances;

'Where a patient lacks capacity under the MCA to make decisions regarding DNACPR, there is a duty to consult with the patient's family and those close to the patient, unless there is a good reason not to do so (e.g., the patient has previously, when he/she had capacity, requested that no such discussion take place). Where a patient who lacks capacity has no one close to them with whom health professionals can consult, and decisions are being made about serious medical treatment (such as the implementation of a DNACPR order), a referral should be made to the local Independent Mental Capacity Advocacy service for an IMCA to be appointed for the patient. In such cases, the role of the IMCA is to check that the best interests principle has been followed ensure that the person's wishes and feelings have been

appropriately considered and to seek a second opinion if necessary. The input of an IMCA may not be available immediately and, if urgent decisions are required to be made before the involvement of an IMCA can be arranged then they should be made in accordance with the patient's best interests; the referral process should not prevent appropriate care planning taking place whilst the input of an IMCA is awaited. However, any decisions made prior to the IMCA's involvement should be reviewed following receipt of the IMCA's report. Information provided by the IMCA must be taken into account when considering a patient's best interests'.

5.3.17 It appears to the panel that GP2 followed the unified policy as he recognised Mrs Grant lacked capacity [albeit on that occasion did not record that decision]. He therefore initiated action to consult with Mrs Grant's son. That consultation was successful and GP2 received confirmation that Mrs Grant's son knew, understood and had no objection to the decision about DNACPR. In those circumstances it is clear from the unified policy that there was no requirement upon GP2 to consult an IMCA.

5.3.18 Although GP2 complied with the unified policy, the SAR panel felt that in view of the time that had elapsed since Mrs Grant had last seen GP2 [approximately 6 months] it would have been better practice for GP2 to have seen Mrs Grant within the last few days prior to a decision being made on DNACPR.

5.3.19 The SAR panel received assurances from the CCG representative on the panel that training has been delivered to all the GP Safeguarding leads in the Stockport area in respect of the Mental Capacity Act.

Actions of NWAS Operator and PM1

5.3.20 The SAR has been provided with a transcript of the telephone call between N1, HCA2 and the NWAS operator [see Appendix D]. NWAS has also provided the SAR with copies of its policies in relation to resuscitation, diagnosis of death and extracts from other policies relating to dealing with choking. These policies are not replicated within this report as they are lengthy. Where appropriate relevant extracts from the policy are included within the body of this report.

5.3.21 As far as the NWAS operator was concerned it appears to the SAR panel that they took no part in any decisions relating to DNACPR. Their role was confined to obtaining information about Mrs Grant and providing advice and support on the telephone to N1 and HCA2 while awaiting the arrival of PM1. Although not germane to the issue of DNACPR, the SAR panel felt it was appropriate to consider the advice the NWAS operator gave concerning not giving back slaps [see paragraph 4.18] as it appeared to differ from the public facing advice given by organisations such as St John Ambulance[31].

5.3.22 NWAS provided the following extract in relation their policy [sic];

[31] http://www.sja.org.uk/sja/first-aid-advice/breathing/choking-adults.aspx

Callers

'In a choking situation over the telephone, the Medical Priority Dispatch System does not advise back slaps.

In an unconscious patient that is choking, and the patient is not breathing, CPR instructions will be initiated.

If the patient is conscious with a complete obstruction (unable to breathe at all), the caller will be instructed to conduct abdominal thrusts (Heimlich manoeuvre).

If the patient is conscious with a partial obstruction (still able to breathe), the caller will reminded not to slap the patient on the back and the EMD will remain on the line to monitor the breathing.

Our advice is governed and instructed by the International Academies of Emergency Dispatch, who utilise worldwide research, guidelines and best practice. This is based on what is best, safest and most like to achieve a positive outcome for a patient that can be safely and adequately managed by a call handler that has to provide this advice in a non-visual environment'.

5.3.23 The SAR panel discussed this point and concluded that, while the advice given by NWAS differed from public facing advice from other organisations, this was because it was being provided under different circumstances. NWAS telephone advice to callers is more sophisticated and advanced than public facing advice on the internet. This is because the operator is giving the advice in a real time situation to a caller who is providing information and feed-back on the condition of the patient and therefore the advice can be modified in response to changes.

5.3.24 Reference to the conversation between the NWAS operator and N1 and HCA2 shows there were frequent questions and exchanges between them as to the condition of Mrs Grant [i.e. was she conscious? Was she breathing?]. It appears that these questions and the responses provided helped the NWAS operator to assess what advice they should give to N1 and HCA2.

5.3.25 The NWAS operator asked on a number of occasions whether Mrs Grant was breathing and received responses that indicated she was, albeit the description given suggests her breathing was not normal. The response on those occasions from the operator was not to use back slaps.

5.3.26 It is only towards the end of the conversation between HCA2 and the NWAS operator that it becomes clear Mrs Grant's breathing has stopped altogether. At that point the operator advises HCA2 to attempt abdominal thrusts [Heimlich manoeuvre]. HCA2 then indicates that Mrs Grant has started breathing again at which point the NWAS operator advises HCA2 not to use back slaps. All of that advice appears to the SAR to have been appropriate and in line with the policy outlined at paragraph 5.3.20.

5.3.27 The SAR discussed the actions of the staff from Cherry Tree House and the way they responded to Mrs Grant's medical needs. They appreciate the staff

very suddenly found themselves dealing with a medical emergency and a resident in a state of trauma. This was a difficult, demanding and stressful situation that needed a quick response. It was one in which there was very little time to save Mrs Grant's life. It seems to the panel that, under the circumstances staff acted instinctively and appeared to do what they thought was the right thing to do under the circumstances.

5.3.28 However, clinicians on the panel questioned why N1 did not follow the training that nurses are given under such circumstances. That is, to use back slaps to try and clear any obstruction in the patient airway. Clinicians also felt that best practice in such emergency situations would have been for N1 to have clearly identified to the NWAS operator that she was a qualified nurse and that she was taking charge.

5.3.29 That would have negated the need for the NWAS operator to relay advice via the telephone through HCA2 and hence shortened the lines of communications. The panel felt N1 could have considered putting the mobile telephone on 'speaker phone', engaged directly with the NWAS operator and given a clear dialogue as to Mrs Grant's condition and the interventions she was applying. The panel recognise that, even if that had happened, it may have made no difference to the eventual outcome for Mrs Grant. The panel have not been able to see N1 and ask her these questions directly.

5.3.30 When PM1 reached Mrs Grant it appears she was unresponsive, gasping and had agonal breathing. PM1 inserted a laryngoscope into Mrs Grant's airway and asked to use suction machine 1 and suction machine 2 both of which were broken. At that point she left Mrs Grant and went to get suction machine 3 from her emergency response vehicle.

5.3.31 NWAS provided the SAR with the following extract in relation to their policy for Clinicians dealing with choking incidents in adults [sic];

Clinicians

'Our Operational clinicians would follow the JRCALC guidance which is as follows:

Adult management

Mild airway obstruction = Encourage the patient to cough but do nothing else. Monitor carefully. Rapid Transport to hospital.

Severe airway obstruction - Conscious patient = Give up to 5 back blows – after each back blow check to see if the obstruction has been relieved. If 5 back blows do not relieve the airway obstruction, give up to 5 abdominal thrusts. If 5 abdominal thrusts do not relieve the obstruction, continue alternating 5 back blows with 5 abdominal thrusts.

Severe airway obstruction – unconscious patient = If the patient is unconscious, begin basic life support. During CPR the patient's mouth should be quickly checked for any foreign body that has been partly expelled each time the airway is opened.

If these measures fail and the airway remains obstructed attempt to visualise the vocal chords with a laryngoscope. Remove any foreign material with forceps or suction.

Additional information:

Chest thrusts/compressions generate a higher pressure than back blows.

Avoid blind finger sweeps. Manually remove solid material in the airway only if it can be seen.

Following successful treatment for FBAO foreign material may remain in the upper or lower respiratory tract and cause complications later. Patients with a persistent cough, difficulty swallowing or the sensation of an object in the throat must be assessed further.

Abdominal thrusts can cause serious internal injuries and all patients so treated must be assessed for injury in hospital'.

5.3.32 It appears to the SAR that Mrs Grant most probably had a severe airway obstruction. PM1 says Mrs Grant was unresponsive and her description of Mrs Grant gasping and agonal breathing indicated that she had not suffered a cardiac arrest. PM1 therefore appropriately followed the guidance in paragraph 5.3.25 of using her laryngoscope and trying to clear any obstruction by suction.

5.3.33 The SAR panel heard there is no requirement, such as through commissioning arrangements with the local authority, for a home like Cherry Tree House to have a suction machine. The SAR panel also recognise there is a difference of opinion as to what a suction machine should be used for in cases of choking. Clinicians on the SAR panel felt they could be used to clear an obstruction 'as far as can be seen into the mouth' although not beyond, for example into the windpipe of a patient.

5.3.34 It is clear from conversations with the Director of the home that the suction machines they had [machines 1 and 2] were only intended for use by staff in the home in clearing the mouths of residents. The Director said they were not intended to be used to enter the airways of patients.

5.3.35 However, these circumstances were different and PM1 needed access to a suction machine in order to complete the procedure outlined in the guidance contained in paragraph 5.3.25. The failure of both machines meant that PM1 had to leave Mrs Grant and return to her vehicle to obtain suction machine 3. That meant there was a delay in the treatment of Mrs Grant. The SAR panel heard that NWAS have now altered the way in which equipment is stored in their vehicles so that paramedics can gain quicker access to suction machines.

5.3.36 The SAR cannot reach a view on how critical that delay may have been. There are simply too many other variables. For example, the panel cannot say whether, had machines 1 and 2 worked, their use would have succeeded in clearing Mrs Grant's airway, particularly as they are not designed for

entering the actual airway. The following is an extract from NHS Derby City Guidelines for using oral suction machines: 'DANGERS • Do not attempt to remove a solid object or an inhaled foreign body from the back of the throat with suction. This could result in the object being forced further into the airway and possibly causing a complete obstruction'. What is evident is that, by the time PM1 returned to Mrs Grant, she had not suffered a cardiac arrest and was still at the point of having a severe airway obstruction. She may, or may not, have been conscious. Continued attempts by PM1 to clear her airway using suction machine 3 therefore appear to have been the appropriate response and in line with the NWAS guidance at 5.3.25.

5.3.37 PM1 applied oxygen to Mrs Grant as it appeared that her airway was clear. Again the SAR cannot reach a view on whether her airway was in fact clear as a short time later she stopped breathing. The fact that PM1 detected Mrs Grant had a 'weak pulse' [see paragraph 4.26] indicates that she had not yet suffered a cardiac arrest although the fact she was not breathing meant she was in respiratory arrest.

Actions of AP1

5.3.38 The SAR has considered the advice that PM1 was given by AP1 not to commence ventilation of Mrs Grant in light of the DNACPR. NWAS procedure on the Diagnosis of Death [henceforth referred to as the DOD procedure] states [page 15];

'In cases where the DNACPR decision cannot be validated, is unclear or there are indications that the patient is end of life (death was expected to occur) then staff must continue to provide care and treatment (including Basic Life Support for cardiac arrests) and seek further advice from an Advanced Paramedic'

5.3.39 PM1 appears to have been told that Mrs Grant had a DNACPR order in place. However, there is no evidence PM1 was shown a copy of that order and hence the decision could not be validated. Therefore PM1's decision to seek further advice from AP1 about ventilation, rather than PM1 ceasing to treat Mrs Grant on the basis they had been told there was a DNACPR order in place was the correct one.

5.3.40 The DOD procedure [paragraph 2.1] states that;

'In patients with cardiac-pulmonary arrest, vigorous resuscitation attempts must be undertaken whenever there is a chance of survival, however remote'

5.3.41 Paragraph 2.4 of the DOD procedure then sets out the conditions under which there is absolutely no chance of survival, and where resuscitation of a patient would be both futile and distressing. They include conditions such as decapitation, none of which applied to Mrs Grant. Hence at this point the conditions appear to have been met for continued resuscitation attempts upon Mrs Grant.

5.3.42 Paragraph 2.5 of the DOD procedure then sets out the criteria which can be used to confirm death and that resuscitation should not be attempted and can be diagnosed by a Paramedic. The procedure states [sic]

<u>All</u> of the following factors must be either present and/or confirmed:

- >15 minutes since the onset of collapse
- Pupils fixed and dilated
- No effective bystander CPR before arrival of the ambulance
- Asystole for >30 seconds on the ECG monitor

5.3.43 Paragraph 2.6 of the DOD procedure states that a valid DNACPR may also confirm that resuscitation should not be attempted. The SAR have carefully considered the DOD procedure and discussed it at length with the panel representative from NWAS to determine whether the advice that AP1 gave to PM1 was compliant with that procedure.

5.3.44 The NWAS representative on the SAR panel explained that she had made enquiries into the actions of PM1 and AP1. The representative understood Mrs Grant had a DNAR in place for dementia, frailty and other ongoing medical issues. At the time of the call to Cherry Tree House Mrs Grant was suffering a potentially reversible first aid emergency. PM1 was correct to seek further clinical advice from AP1. However during the conversation around whether or not resuscitation should take place, there was no mention of the choking incident. The choking incident should have been discussed to give AP1 a clearer understanding of what the cause of the cardiac arrest was. The NWAS representative said it is likely that the outcome from the contact call would have been to initiate cardio pulmonary resuscitation, as the cardiac arrest did not happen because of natural causes.

5.3.45 However, the NWAS representative said that, on the balance of probability, the likelihood is that the decision not to attempt resuscitation was in the best interests of the patient. If resuscitation had been attempted the chances of survival for an asystolic cardiac arrest in this age group is extremely low. The NWAS representative said there was also the need to consider the ethical implications of subjecting a 93-year old lady to the trauma associated with an advanced life support attempt and the quality of life that Mrs Grant would have had if the resuscitation was successful.

5.3.46 The SAR agreed with the assessment of the NWAS representative and felt it was important to consider the following extract from the guidance [page 7];

'.....it is not appropriate to prolong life at all costs with no regard to its quality or to the potential harms and burdens of treatment or to the patient's wishes. The decision to use a treatment should be based on the balance of risks and benefits to the individual receiving the treatment. This principle applies to any treatment, including cardiopulmonary resuscitation [CPR]'

Findings in respect of Key Line 2

5.3.47 The SAR concluded that in respect of any DNACPR decision in 2016 there is no documentation and therefore it is not possible to say what processes were followed, whether they complied with the guidance or unified policy or whether GP1 ever spoke to Mrs Grant's son. The lack of any documentation to confirm whether or not Mrs Grant's capacity was assessed is poor.

5.3.48 While the decision concerning Mrs Grant's leg swelling is not germane to the issue of DNACPR it again demonstrates the lack of documentation concerning her capacity. In relation to that decision there was also no consideration to involve her family or an IMCA, which if she was lacking capacity would have been the appropriate course of action.

5.3.49 GP2 assessed and documented a lack of capacity in Mrs Grant when he first considered DNACPR in April 2017. GP2 did not issue a DNACPR order at that time. They did assess Mrs Grant lacked capacity although the documentation of this was sparse.

5.3.50 When GP2 revisited the issue of capacity in September 2017 they did not have a face to face consultation with Mrs Grant. While they did not assess her capacity they assumed correctly that because of the progressive and irreversible condition Mrs Grant had, she would still lack capacity. While the SAR understands the logic of that decision, and the need to avoid bureaucracy in a busy GP practice, it feels it would have been good practice for GP2 to have set out why he concluded Mrs Grant did not have capacity. The SAR also conclude that, given the period of time that had elapsed since GP2 had last seen Mrs Grant, it would have been good practice to have seen her within the last few days prior to a decision being made on DNACPR.

5.3.51 In all other respects the SAR felt that GP2 had complied with the guidance and unified policy.

5.3.52 The SAR have not been able to speak to N1 and therefore have relied almost entirely upon her witness statement. They have not been able to establish why N1 did not follow the training given to nurses in cases of choking which is to use the five back slaps approach and instead tried to use a suction machine. The SAR have also not been able to establish why N1 did not make it clear to the NWAS operator that she was a nurse and that she was taking charge of the patient. This would have improved communication and clarified the role of the NWAS operator who assumed throughout that they were the senior clinician and were in charge of the situation.

5.3.53 The SAR has carefully considered the role of the NWAS operator took in the treatment of Mrs Grant and found that they complied with the policy of NWAS in relation to giving correct advice to N1 and HCA2. The SAR noted there was a difference in relation to the policy of NWAS and other organisations such as St John Ambulance in relation to back slaps. The SAR recognised this was because of the more advanced levels of life support that NWAS provide.

5.3.54 The SAR considered the role of PM1. They found that PM1 appeared to have correctly followed the NWAS policy for Clinicians in relation to responding to choking up to the point at which they consulted AP1. PM1 tried to use a laryngoscope and suction to clear Mrs Grant's airway. Both of the suction machines owned by Cherry Tree House failed. This built in a delay while PM1 returned to her vehicle to get suction machine 3. There are too many variables for the SAR to reach a view upon whether, had either machine 1 or 2 been in working order, PM1 would have been successful in removing the blockage from Mrs Grant's airway.

5.3.55 The options open to PM1 were limited to trying to remove any obstruction with suction. This appears to have been partially successful. When Mrs Grant's breathing stopped PM1 took the correct course of action in line with the DOD procedure by seeking advice from AP1.

5.3.56 In relation to AP1, the SAR found that because PM1 did not tell AP1 that Mrs Grant's condition was due to choking, then AP1 did not have all the information available. They did not know that Mrs Grant had a potentially reversible condition. Consequently they gave advice to PM1 to cease resuscitation when in fact, the advice under these circumstances is to continue.

5.3.57 Having considered all of the circumstances, the SAR panel cannot say if any of these alternative courses of action had been followed Mrs Grant would have survived. There are simply too many variables. They also recognise that, had attempts to resuscitate Mrs Grant continued, they would have resulted in resulted in other trauma because of the invasive and traumatic medical intervention that resuscitation involves.

5.3.58 Given the comorbidities that Mrs Grant had, her age and frailty the SAR conclude that, while NWAS policy may not have been followed and there was a failure to communicate the fact she was choking, on balance the decision not to continue resuscitation was not inappropriate. The panel recognise that the circumstances would have been very different had the patient been, for example, a child or young person in which the balance of risks and benefits would have been very different.

5.4 Key Line 3

To identify the operating policy and maintenance record of the Care Home's suction machines including the training given to staff in their operation.

5.4.1 In her statement to HM Coroner, the Detective Inspector from GMP responsible for the investigation into Mrs Grant's death says she contacted the UK supplier of the suction machines. She established they are supplied with an instruction manual only, and there is no advice regarding testing or compliance checks.

5.4.2 L & M in their IMR relating to this incident also state the manufacturer of the suction machines does not have any specific guidelines regarding

maintenance. L & M says they PAT test[32] the machines annually to ensure they are safe. They also say weekly in-house suction machine test checks are in place each Friday.

5.4.3 The Detective Inspector from GMP says no compliance checks were available for inspection and none had been completed. L & M state it was evident that the weekly checks had not been routinely completed. L & M have identified an action within their plan [see Appendix E] relating to the testing of machines.

5.4.4 It is clear from the statement provided by HCA1 that she had no prior training or knowledge about how to operate a suction machine [see paragraph 4.3.8]. Similarly HCA2 says in her witness statement that she had never been trained in using a suction machine and had never been shown how one would be used although she did know there were two machines stored in the treatment room. The SAR panel understands that health care assistants employed by L & M at Cherry Tree House are not permitted to operate suction machines which is a procedure for trained nurses.

5.4.5 N1 is a qualified nurse. She is recorded on the register of the Nursing and Midwifery Council as a 'Registered Nurse-Adult' and her registration was valid on the day Mrs Grant died. She had received training in the use of suction machines 6-10 years before the incident involving Mrs Grant. She had worked at Cherry Tree House for four weeks and during that time had not received any training on suction machines.

5.4.6 When the Chair and Author of the SAR met with the Director they discussed the issue of the suction machines. The Director confirmed that neither suction machine 1 or 2 had been subjected to weekly checks. It appeared staff knew one of the machines was not working although they did not tell anyone. The Director was not able to establish why. They felt management at the time may have wrongly assumed checks had been carried out when they had not.

5.4.7 The Director explained that the suction machines at the Nursing Home were only for use in situations in which there was a need to clear a resident's mouth of debris. They were not intended to be part of any life-saving equipment. The Director is a qualified nurse and says that during her career elsewhere she has seen suction machines used to try and deal with choking when her understanding is that the correct first aid procedure is to give five back slaps. She was not able to explain why N1 resorted to using suction machine 1 instead of giving back slaps.

5.4.8 The Director explained in some detail the steps that had been taken in Cherry Tree House following the death of Mrs Grant. Within 24 hours a choking care plan was written for all residents that might be at risk. There had been an immediate revision of the choking procedure and this included

[32] Portable Appliance Testing [PAT] is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use. Most electrical safety defects can be found by visual examination but some types of defect can only be found by testing.

choking risk assessments being undertaken and an audit of all patient files. First aid training is in place and this includes the 5 back slaps. The Director explained that immediate steps had been taken to implement a regime for the weekly testing of suction machines.

5.4.9 The SAR panel discussed the issue of choking. The panel were told Mrs Grant did not wear her dentures. A health professional on the panel pointed out that when this happens it is important a choking risk assessment is carried out.

5.4.10 The panel were reassured, in Mrs Grant's case, that had happened and she was assessed as at low risk of choking. The SAR felt there was learning here for other residential care and nursing homes that may not be following that approach and should now ensure risk assessments are carried out.

5.4.11 The panel also heard that earlier in the morning of 28 September 2017 Mrs Grant may have had difficulty swallowing a tablet. There is reference to this event in the telephone conversation between N1, HCA2 and the NWAS operator. The SAR panel felt that, if Mrs Grant had experienced difficulty swallowing or had started to choke earlier that day, it would have been good practice for staff to have identified the incident and revised the choking risk assessment and felt there is learning here for all residential care and nursing homes.

Findings in respect of Key Line 3

5.4.12 The SAR found that neither suction machine 1 or 2 had been subject to weekly checks to ensure they were working correctly. They should have been checked and it seems some staff may even have known that suction machine 1 was not working before this incident. The SAR has not been able to establish why staff were not checking the machines when they should have been nor why, if they knew, they did not act to have suction machine 1 repaired.

5.4.13 Suction machines at Cherry Tree House are only intended for use in clearing debris from resident's mouths and not for clearing airways or saving life. Staff at Cherry Tree House are trained to follow the 5 back slaps approach.

5.4.14 Consequently, under any other circumstance, the failure of either one or both of the machines would not have been as impactive as it was never envisaged they would be used in situations where an attempt was being made to save life. It therefore appears to the SAR that nobody in Cherry Tree House might have been reasonably able to envisage anyone else needing them to try and save life.

5.4.15 The SAR has not been able to establish why N1 started to use a suction machine instead of trying to clear Mrs Grant's airway by using five back slaps. She had not been trained at Cherry Tree House to use one. While she states she had been trained some years ago in their use the SAR has not been able to establish if that training was for clearing debris from the mouth or instead for some form of advanced life-saving that involved the use of

suction. The SAR are not able to reach finding as to whether, had suction machine 1 been working, N1 might have succeeded in clearing Mrs Grant's airway. There are too many variables.

5.4.16 PM1 had training in advanced life-saving and the NWAS DOD procedure includes the tactical option of using suction when attempting to clear a severe airway obstruction. Hence, suction machine 1 and suction machine 2 would have been of use to PM1 in her attempts to remove the obstruction in Mrs Grant's airway. Again there are simply too many variables to say what might have happened had either of the machines been in working order and PM1 had been able to use them and whether she would have been successful in clearing Mrs Grant's airway.

5.5 Key Line 4

To identify what training, including: dietary, basic life support and first aid, employees of the Nursing Home and agency staff working in the Nursing Home underwent to enable the effective discharge of their duties.

5.5.1 HCA1 started work at Cherry Tree House three weeks before the death of Mrs Grant. When she joined L & M Healthcare she had no first aid, CPR or health care training. HCA1 says she was given an induction course on moving and safe handling and had twelve weeks to complete an e learning package. On the date Mrs Grant died, HCA1 had not completed any of this package as she was still waiting for her on-line user details.

5.5.2 HCA2 had worked for L & M Healthcare at Cherry Tree House for three and a half years and held an NVQ Level 3 in health and social care. She had been trained to give medication, take blood and blood pressure. She completed a first aid course in 2017. She describes this as a three days course called 'train the trainer' that included CPR training.

5.5.3 As described earlier in paragraph 5.4.5, N1 is a qualified nurse. As such she will have been trained to a standard that involves compliance with the code that governs the professional standards that nurses must uphold[33]. The SAR panel would expect that N1 would be able to demonstrate professional competency in at least basic life support and first aid and most probably to a standard beyond that which would be expected amongst other members of staff on duty at Cherry Tree House. That may explain why she tried to use suction machine 1 in response to Mrs Grant's choking. However that does not explain why she did not first try to use the five back slaps approach which is the way in which nurses are trained to deliver first aid in choking situations.

[33] The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates. Nursing and Midwifery Council (Updated Oct 2018) https://www.nmc.org.uk/standards/code/

5.5.4 On the date of the incident N1 had completed 4 weeks of a 13-week probationary period with L & M Health Care. It is not clear what, if any, additional training N1 had completed with L & M Healthcare.

5.5.5 When the Director met with the SAR Chair and Author she explained the induction process that HCA1 would have gone through. She said the process lasted one week and included shadowing an experienced member of staff. The Director explained that new staff have to sit at a computer and complete a learning package that includes training in moving and handling, food safety, dementia, first aid, health and safety, control of substances hazardous to life (CoSHH), data protection, end of life care, infection control and the MCA.

5.5.6 The Director was not able to explain how much of this course HCA1 had completed at the time of Mrs Grant's death as it was not possible to access the computer training records and HCA1 has now left the company. The Director said she was reassured that HCA1 had completed some training and was displaying competence and a basic level of proficiency because of the way she dealt with Mrs Grant. For example, she clearly understood Mrs Grant's dietary preferences, the need to assist her with a spoon, to give a back slap when Mrs Grant began to choke and the need to quickly get help when this did not work.

Findings in respect of Key Line 4

5.5.7 From the testimony of N1 and HCA2 and from examination of records held by HM Coroner, the SAR believe they had appropriate levels of training in dietary, basic life support and first aid while employed at Cherry Tree Care Home.

5.5.8 HCA1 had a much lower level of training. In her witness statement she says she had not been able to complete the e learning package which contained many of the modules described by the Director. It was not possible to establish if that was the case as the Director was not able to access the computer training records.

5.5.9 When HCA1 was deployed to care for Mrs Grant she would have been under the supervision of a trained mentor. There were many other staff around that day and the actions of HCA1 demonstrated she knew Mrs Grant reasonably well and understood her dietary and eating requirements. HCA1 was assisting Mrs Grant to eat and was giving her a soft diet of rice and beef stroganoff. There is no evidence to suggest the manner in which HCA1 was undertaking this task caused Mrs Grant to choke. The SAR found the actions of HCA1 when Mrs Grant started to choke was correct. She slapped her on the back and when this did not work immediately went to get help.

5.5.10 It only took a matter of moments for N1 and HCA2 to respond to the incident. The SAR felt that the immediate actions of those staff was in line with the training they would have received. As a nurse N1 had a higher level of training than HCA2 and appeared to take the lead in trying to clear Mrs Grant's airway. However, N1 did not make it clear to the NWAS operator

that she was a nurse and that she was taking charge of the treatment of Mrs Grant. HCA2 remained on the telephone to the NWAS operator relaying information and advice about Mrs Grant's condition until PM1 arrived. Had N1 made her role clear to the NWAS operator there may have been a different dialogue over the telephone. For example, knowing N1 was a trained nurse, the NWAS operator may have advised her to try back slaps.

5.5.11 While there may have been some gaps in the training that N1 and HCA1 had received at Cherry Tree House, the SAR are not able to conclude that they contributed to the death of Mrs Grant. There are still gaps in the information the panel have. For example the panel have not been able to establish why N1 did not attempt to use back slaps on Mrs Grant when that is the recognised approach for patients that are choking. Even if N1 had tried that approach it is not possible to say it would have been successful in clearing Mrs Grant's airway.

5.6 Key Line 5

To identify whether North West Ambulance Service staff who attended the Nursing Home at the time of Mrs Grant's death had a full complement of equipment to deal with Mrs Grant's needs.

5.6.1 The IMR from NWAS states that;

'...the NWAS staff who were in attendance at the Care Home had all of the equipment required to deal with any pre-hospital emergency that they were faced with'

5.6.2 The IMR goes on to state that the Paramedic in attendance at the incident [PM1] carried in three bags and the defibrillator. It is clear from the information provided, both by PM1 and N1 that the oxygen tank PM1 brought with her into Mrs Grant's room when she first arrived was empty. PM1 explained in a statement that she had checked the oxygen level in the cylinder at the beginning of the shift and it was appropriate and assumed there must have been a leak.

5.6.3 The NWAS representative on the SAR told the panel that the issue of the empty oxygen cylinder had been looked into. NWAS has established that PM1 did check the cylinder when she came on duty and it was full. It appears what happened is that the delivery valve was opened inadvertently possibly due to it catching against the bag it is contained in. This caused the cylinder to empty. This has been a point of reflection for the future work of the paramedic concerned.

Findings in respect of Key Line 5

5.6.4 The SAR panel do not feel the empty oxygen cylinder was an issue in Mrs Grant's death for the following reasons. If Mrs Grant's airway was blocked, the application of oxygen was futile. With an obstructed airway, the oxygen would not have entered Mrs Grant's lungs and would have vented back into

the atmosphere. It appears to the SAR panel therefore that the first priority was to clear Mrs Grant's airway.

5.6.5 When PM1 first arrived at the room she checked Mrs Grant's airway with a laryngoscope and said she could see 'secretions'. The SAR panel has not been able to establish precisely what these 'secretions' were, how deeply within Mrs Grant's airway they were located, nor whether they were blocking it partially or completely. Neither has the panel been able to establish or exclude whether there was a blockage in Mrs Grant's airway at some other place, possibly below where PM1 saw the 'secretions'. The only fact that can be established with some certainty is that Mrs Grant's airway was blocked by something.

5.6.6 The guidance to clinicians in this situation is set out earlier at paragraph 5.3.25 and one of the tactical options is the use of a suction machine. Because neither suction machine 1 nor 2 was working, PM1 left the room to go to the emergency response vehicle to get suction machine 3. Consequently, because Mrs Grant's airway was blocked PM1 was not in a position to apply oxygen at that stage hence negating the immediacy of the empty oxygen bottle.

5.6.7 When she had obtained and used suction machine 3, PM1 describes Mrs Grant as taking a shallow breath. At that point PM1 was able to give Mrs Grant oxygen from the fresh bottle she brought back from the emergency response vehicle. However, that did not have an effect in Mrs Grant's case as she then stopped breathing. The reason for that is almost certainly because there was a blockage of her airway which was caused by aspirated food: a fact stated from the post mortem as the intermediate cause of her death.

5.7 Key Line 6

To identify whether there was continuity of any DNAR status attached to Mrs Grant when she moved from Wythenshawe Hospital to the Nursing Home.

5.7.1 There are references within information provided by Mrs Grant's previous GP surgery that, while she was a resident in the care home in Cheadle, GP1 planned to discuss the issue of DNACPR. The IMR author for the CCG has not been able to establish if that happened [see paragraph 3.2.3]. As outlined in paragraph 3.2.4 there was no evidence of a capacity assessment nor the involvement of an IMCA.

5.7.2 A short entry in Mrs Grant's medical notes dated 12 June 2016 from a Locum doctor contains the short phrase 'Community DAR in situ'. This is the only written evidence the SAR panel has seen to indicate such a decision had been made in respect of Mrs Grant. While the SAR panel has not spoken directly to her son, the e mail he sent on 7 September 2017 [see paragraph 3.2.12] indicates an advanced decision relating to DNACPR may have been made seven years before.

5.7.3 The phrase used in the e mail 'My mum signed such a statement when she was aware' suggests that when Mrs Grant made that decision, around 2010, she had capacity. The SAR panel has not been able to identify any documentation to confirm when and where that decision was made.

5.7.4 Other than a copy of the DNACPR issued by GP2 on 8 September 2017 [see paragraph 3.2.13], the SAR panel has not seen written documentation that either an advanced decision to refuse treatment [ADRT] or a DNACPR form existed in respect of Mrs Grant before that date.

5.7.5 Page 16 paragraph 7.1 of 'the guidance' states;

'Unless there is a valid and applicable advance decision to refuse treatment [ADRT], specifically refusing CPR, a CPR decision form is not binding. The form should be regarded as an advanced clinical assessment and decision, recorded to guide immediate clinical decision making in the event of a patient's death or cardiorespiratory arrest. The final decision regarding the application or not of the CPR decision in an emergency rests with the healthcare professionals responsible for managing the persons immediate situation'.

5.7.6 Page 18 paragraph 9.1 of 'the guidance' states

'CPR must not be attempted if is contrary to a valid and applicable ADRT [in England and Wales] made when the person had capacity'

5.7.7 In England and Wales advanced decisions are covered by the MCA 2005. The Act confirms that an ADRT refusing CPR will be valid and therefore legally binding if the following seven circumstances are met;

- The person was 18 years old or over and had capacity when the decision was made;
- The decision is in writing, signed and witnessed;
- It includes a statement that the advanced decision is to apply even if the person's life is at risk;
- The advanced decision has not been withdrawn;
- The person has not, since the advanced decision was made, appointed a welfare attorney to make decisions about CPR on their behalf;
- The person has not done anything clearly inconsistent with its terms;
- The circumstances that have arisen match those envisaged in the advanced decision.

'If an ADRT does not meet these criteria but appears to set out a clear indication of the person's wishes, it will not be legally binding but should be taken into consideration in determining the persons best interests'

Findings in respect of Key Line 6

5.7.8 The panel is satisfied, based upon the e mail sent by Mr Grant and from brief references within her medical notes that an ADRT had most probably

been made by Mrs Grant around 2010 to refuse CPR. However, in the absence of the document upon which the decision was recorded the SAR panel concludes that when Mrs Grant entered and left Wythenshawe Hospital the ADRT concerning DNACPR did not meet the test set out above in the MCA 2005.

5.7.9 Consequently, had circumstances arisen either during her stay in hospital or her residence in Cherry Tree House before 8 September 2017 in which CPR would have to be considered, clinicians would not have been legally bound by the terms of the MCA 2005. Instead any decisions about applying CPR, or not, would have had to be made in line with 'the guidance' and specifically page 16 paragraph 7.1. However, as far as the SAR panel are able to ascertain, that situation did not occur.

6. LEARNING

6.1 The SAR panel identified the following learning. A narrative sets the context for each piece of learning. Where a piece of learning links to a recommendation a cross reference is included.

Learning 1 (Panel Recommendation 1) (Agency Recommendation 1, 2, 3, 4, 6)
Narrative
While GP2 followed the guidance and unified policy relating to DNACPR and the Mental Capacity Act, they had not held a face to face consultation with Mrs Grant for about six months.
Learning
Ideally, GPs who draw up DNA CPRs for residents in nursing and care homes should see the person in the few days before doing so in order to assess their physical health and mental capacity.

Learning 2 (Panel Recommendation 2) (Agency Recommendation 5, 7 & 8)
Narrative
Cherry Tree House held suction machines for the purpose of clearing debris from resident's mouths. The training of staff in the home in relation to choking was to administer five back slaps and it was not intended that these suction machines should be used as alternatives to that method. When Mrs Grant started to choke PM1, who had advanced life-saving skills, tried to use two of the home's suction machines to clear an obstruction in Mrs Grant's airway. Neither machine was working. This meant there was a delay while PM1 fetched a suction machine that did work from her vehicle.
Learning
All potentially lifesaving equipment in care and nursing homes should have a written maintenance and testing policy and an audit log of the test results.

Learning 3 (Panel Recommendation 3)
Narrative
When she arrived at Cherry Tree House it was found Mrs Grant preferred not to wear her dentures when eating. In her case Cherry Tree House correctly ensured a risk assessment was undertaken. This indicated she was at a low risk of choking.

Learning
All nursing and residential homes need to ensure that a choking risk assessment is completed in cases when a resident indicates they do not wish to wear their dentures.

Learning 4 (Panel Recommendation 4)
Narrative
On the day she died it appears Mrs Grant may have struggled to swallow medication earlier that morning. Although this was not the cause of the choking incident that led to her death. In response to the issue with medication, staff did not revisit the risk assessment that had been completed when Mrs Grant entered Cherry Tree House to assess whether the risk of choking had altered.
Learning
When a resident in a nursing or care home struggles to swallow medication or food an immediate risk assessment should be undertaken and if necessary a referral made to a speech and language therapist and the incident documented.

Learning 5 (Panel Recommendation 5)
Narrative
N1 did not identify to the NWAS operator that she was a nurse and had taken responsibility for Mrs Grant's care. After initially speaking to the operator, HCA2 took over because Mrs Grant was in a different room from where the telephone was located. This led to some delay and possibly mixed information being relayed between N1, HCA2 and the operator. Eventually HCA2 moved to the room where Mrs Grant was located and resumed her conversation with the NWAS operator on a mobile telephone.
Learning
A person in a nursing or care home who makes a 999 call for an ambulance should ideally be in the same room as the resident who needs help. This avoids messages having to be relayed and shortens the line of communication.

Learning 6 (Panel Recommendation 6)
Narrative
When Mrs Grant suffered a respiratory arrest, PM1 who knew that a DNACPR order was in place, contacted AP1 for advice. PM1 did not tell AP1 that Mrs Grant was choking. Hence AP1 advised PM1 to cease resuscitation on Mrs Grant.
Learning
Paramedics seeking advice from other professionals should ensure they provide all the relevant information to enable the best advice to be provided.

Learning 7 (Panel Recommendation 7) (Agency Recommendation 9)
Narrative
HCA1 had not completed all of the training programme that was a requirement of her induction to Cherry Tree House. That included training on first aid. N1 was a registered nurse who had completed training as a nurse. She had not completed her induction training for Cherry Tree House. N1 did not follow the training that is given to nurses in cases of choking to deliver five back slaps. The SAR panel has not been able to speak to N1 to establish why she did not follow her training.
Learning
Nursing and care homes need to have excellent induction programmes so that new staff are competent, and feel confident, in dealing with emergencies.

Learning 8 (Panel Recommendation)
Narrative
When PM1 arrived at the Romiley Unit the oxygen cylinder that she took from her emergency response vehicle was empty. PM1 had checked the cylinder when she came on duty and it was full. It appears the reason the cylinder discharged was because a valve may have become caught on the bag it was contained in.

Learning
Staff employed by NWAS that use oxygen cylinders as part of their emergency response equipment need to be aware that under some circumstances, oxygen cylinders may be inadvertently discharged.

7. GOOD PRACTICE

7.1 The SAR panel did not identify any examples of good practice. However, they recognised that most professionals appeared to have correctly followed their agencies procedures and the training they had been given. Where there are gaps, these have been identified within the body of the report and as learning and recommendations where appropriate.

8. CONCLUSIONS

8.1 Mrs Grant was 93 years of age and had been resident in Cherry Tree Nursing Home in Stockport having been discharged from hospital in April 2017. She had advanced dementia and her health was failing. At some time before she went into hospital it appears a DNACPR order may have been put in place in relation to her. The SAR was told no record could be found of this event. A decision concerning DNACPR is very important and consequently there should be good record keeping and continuity of such decisions.

8.2 At some time before she was admitted to hospital Mrs Grant was found to have a leg swelling. This was not investigated because the clinician concerned felt it was not in Mrs Grant's best interests. There is no record that a capacity assessment was conducted, nor in view of the fact her son was not contactable, was consideration given to involving an IMCA. Again it is important that when capacity is considered the outcome and reasons are recorded as is the need to consult an IMCA.

8.3 Mrs Grant was visited by a doctor [GP2] in April 2017 when she entered Cherry Tree House. He assessed her as lacking capacity although he did not document why he reached that decision. It would have been good practice to record why GP2 felt that Mrs Grant lacked capacity.

8.4 On 7 September 2017 staff from Cherry Tree House spoke to GP2 on the telephone about Mrs Grant. It appears that Mrs Grant's health was failing and it is likely she was reaching the end of her life. GP2 felt that CPR was unlikely to be successful because of Mrs Grant's age and comorbidities. The decision to consider a DNACPR at that stage was therefore reasonable.

8.5 GP2 did not record a capacity assessment because he felt that, with a progressive and irreversible condition (vascular dementia) it was obvious that she would still lack capacity. GP2 initiated contact with Mrs Grant's son through the home so as to ensure he was aware of the decision to issue a DNACPR order. Mrs Grant's son responded and confirmed his agreement. The DNACPR order was issued on 8 September 2017.

8.6 GP2 followed the guidance and unified policy in relation to issuing the DNACPR order. However the fact he did not record a capacity assessment was an omission. The SAR panel also felt that in view of it having been about 6 months since he had seen her, GP2 should have arranged to visit Mrs Grant for a face to face consultation.

8.7 Cherry Tree House knew that Mrs Grant did not wear her dentures and preferred softer food. A choking risk assessment conducted in July 2017 indicated that Mrs Grant was at low risk of choking. Although Mrs Grant was not on a special diet she needed assistance with meals. This involved a member of staff feeding her with a teaspoon.

8.8 At some time during the morning of 28 September 2017 it appears Mrs Grant may have had difficulty swallowing a tablet. The details of that event are sparse as the SAR has not had the opportunity to speak directly to the

staff involved. They have not therefore been able to establish whether they considered re-assessing the risk to Mrs Grant of choking. The SAR panel felt it would have been good practice for such an assessment to have been undertaken.

8.9 About 12.30hrs that day, while HCA1 assisted Mrs Grant with her lunch, she started to choke. HCA1 slapped Mrs Grant on the back. Although HCA1 had not completed her induction course that was the correct thing to do. It did not appear to clear the blockage and HCA1 went for help. N1 responded and took charge of Mrs Grant's care. Although she is a registered nurse, the SAR has not been able to establish why she did not follow the recognised response to choking of delivering five back slaps.

8.10 Instead N1 looked in Mrs Grant's mouth and, although she saw 'nothing obvious to the eye', she asked another member of staff to bring one of the home's suction machines. N1 had not been trained by the home as she had not completed the home's induction training course. However she indicates in her statement that she had been trained some years ago in the use of a suction machine. Suction machine 1 did not work. N1 telephoned for an ambulance using a land-line in the office and immediately returned to Mrs Grant.

8.11 While N1 tended to Mrs Grant, HCA2 had a conversation with the NWAS operator. Although the recording of that conversation contains reference that staff attending Mrs Grant are nurses, there was no indication that N1 told the NWAS operator she was a nurse and that she was taking charge of Mrs Grant's care. Consequently the NWAS operator maintained a conversation with HCA2 giving advice in response to reports from HCA2 as to Mrs Grant's condition. This led to some repetition and uncertainty as to Mrs Grant's condition. For example, whether she was conscious and/or breathing.

8.12 Had the NWAS operator known that N1 was a nurse, the conversation may have been different. For example, rather than relying on information from HCA2, the NWAS operator would have known they were conversing with a trained nurse [N1] and therefore may have been able to advise back slaps. However, there are too many variables for the SAR panel to reach any conclusions as whether the use of back slaps would have been successful in removing any obstruction from Mrs Grant's airway.

8.13 When PM1 arrived, she found Mrs Grant was unresponsive. She used a laryngoscope and found secretions in Mrs Grant's mouth. She asked to used suction machine 1 and was told it did not work. When suction machine 2 was brought this did not work either. At the same time PM1 found that the oxygen cylinder she brought from her vehicle was empty. PM1 therefore had to leave Mrs Grant to fetch an NWAS suction machine [machine 3] and at the same time a spare oxygen cylinder.

8.14 Using suction machine 3, PM1 was able to clear what appeared to be rice from Mrs Grant's airway. When Mrs Grant appeared to take a breath PM1

gave her oxygen, however, Mrs Grant then appeared to stop breathing again and was in respiratory arrest. Unless Mrs Grant's breathing was re-started then it was inevitable she would then go into cardiac arrest. PM1 contacted AP1 for advice. Up until that point the SAR panel heard that PM1 had correctly followed her training and the DOD policy of NWAS.

8.15 During the conversation PM1 then had with AP1, she did not say that Mrs Grant had suffered a choking episode. Choking is a potentially reversible condition and therefore the DOD policy is that resuscitation should continue. Not knowing that Mrs Grant was choking, and in the light of the DNACPR order, AP1 advised PM1 not to resuscitate Mrs Grant and she died.

8.16 The SAR panel cannot say if, had attempts to resuscitate Mrs Grant continued, they would have saved her life. The panel recognise that resuscitation involves invasive and traumatic medical intervention and the chances of Mrs Grant surviving it were likely to be relatively low.

8.17 The SAR recognises that one of the main messages included in the guidance [message 20] includes the following;

'The final decision regarding whether or not attempting CPR is clinically appropriate and lawful rests with the healthcare professionals responsible for the patient's immediate care at that time'

8.18 Given the comorbidities that Mrs Grant had, her age and frailty the SAR conclude that, while NWAS policy may not have been followed and there was a failure to communicate the fact she was choking, on balance the decision not to continue the resuscitation was not inappropriate. The panel recognise that the circumstances would have been very different had the patient been, for example, a child or young person in which the balance of risks and benefits would have been very different.

8.19 Notwithstanding that conclusion, the SAR still feel there is valuable learning and recommendations emerging from this case that it has set out in sections 7 and 9 of this report.

Addendum to the Panel's Conclusions

8.20 As described in paragraph 3.2.8 et al, additional information was brought to the attention of the panel by HM Coroner for South Manchester following the inquest into the death of Mrs Grant and after the panel had completed its work.

8.21 The panel has set out in some detail, within those paragraphs, the information it has received regarding the choking risk assessment. The panel heard that, while there have been errors in computation and addition, a review by the Operations Director for Cherry Tree House found that the correct score for Mrs Grant was 24. The panel therefore remain of the view that Mrs Grant was at low risk of choking and believe the food she was being fed at the time she died was appropriate to that risk level. The panel found the choking risk assessment was not reviewed monthly as it should have been. The panel cannot reach a judgment as to what, if any,

differences that might have made in respect of the risk of choking band that Mrs Grant was in when she died. However, the panel feels there is a need to ensure staff are competent in completing risk assessments and accordingly they have enhanced recommendation ix.

8.22 In relation to weight loss, the panel has considered the information supplied by Cherry Tree House. Using the MUST tool, it appears to the panel that Mrs Grant weight and BMI meant she fell within the high risk of malnutrition banding when she entered the home and remained in that banding until her death. Using the guidance in the MUST tool, Mrs Grant should have been treated for weight loss and Cherry Tree House should have considered referral to a dietitian, a nutritional support team or a local protocol.

8.23 Cherry Tree House did implement a weight loss care plan in respect of Mrs Grant. It seems to the panel this was an appropriate thing to do and was in line with the MUST guidance to treat patients that fall within the high risk of malnutrition banding. Cherry Tree House say that a referral to a dietitian was not made as staff took advice from GP2. It is not clear to the panel when that advice was given. The only record of advice given by GP2 in respect of weight loss was on 7 September 2017, when GP2 is recorded as advising '[sic] to monitor and encourage as much as can'

8.24 It appears that GP 2 had a local weight loss protocol in place in respect of nursing home residents. The local protocol developed and used by GP2 advised nursing homes to inform the GP routinely if a resident's weight loss was greater than 10% over a period of two months. Using the weights recorded for Mrs Grant, she would not have reached that requirement.

8.25 Given that Cherry Tree House had implemented a plan to address both Mrs Grant's nutritional needs and her weight loss which was in line with the advice given by GP2 on 7 September, it is not clear what additional value a referral to a dietitian would have achieved. Notwithstanding that, the panel feel there is a need for clarity to be established between Care Homes and GP surgeries as whether the guidance within MUST or local protocols should be followed when responding to weight loss.

9. RECOMMENDATIONS

9.1 The SAR panel makes the following recommendations;

i. That Stockport Clinical Commissioning Group [CCG] should ensure GPs are familiar with the Resuscitation Council's guidance on DNACPR decisions as detailed in the document "Decisions Relating to Cardiopulmonary Resuscitation" (2016);

ii. That Stockport Safeguarding Adults Board [SSAB] consider writing to the Resuscitation Council to determine its view on whether a person subject to a DNR CPR decision should have been seen by the doctor making it within the prior week;

iii. That Stockport Safeguarding Adults Board [SSAB] should satisfy itself that in nursing and care homes where any equipment is required to support an individual, this should be checked weekly to ensure that this is effective and there should be a robust contingency plan where the equipment is found not to be working;

iv. That SSAB should satisfy itself that nursing and care homes in its area know that a choking risk assessment is undertaken when a resident indicates they do not wish to wear their dentures when eating;

v. That SSAB should satisfy itself that nursing and care homes in its area know that when a resident struggles to swallow medication or food an immediate risk assessment should be undertaken and if necessary a referral made to a speech and language therapist and the incident documented;

vi. That SSAB should satisfy itself that nursing and care homes in its area know that when staff call 999 for an ambulance they do so from the room, the resident needing help is in;

vii. That SSAB should satisfy itself that North West Ambulance [NWAS] has reviewed the information sharing between paramedic 1 and the advanced paramedic.

viii. That SSAB should satisfy itself that registered nurses and care staff in nursing and care homes in its area have induction programmes that provide new staff with knowledge and competence to effectively deal with emergency situations, and that registered nurses are fully aware of the professional standards and evidence their revalidation;

ix. That SSAB should satisfy itself that nursing and care homes in its area have induction programmes that provide new staff with knowledge and competence to undertake and complete risk assessments and effectively deal with emergency situations;

x. That NWAS are satisfied staff that use oxygen cylinders are aware that they may accidentally discharge under certain circumstances and know how to prevent this happening;

xi. That SSAB work with Stockport Clinical Commissioning Group [CCG] to ensure there is clarity between GPs and Care Homes as to the appropriate response to concerns about weight loss in residents.

GLOSSARY

AP1	Advanced Paramedic.
ASC	Stockport Metropolitan Borough Council Adult Social Care.
asystole	A condition in which the heart ceases to beat.
ADRT	Advanced decision to refuse treatment is a written statement which lets other people know about any specific treatments that you do not want to have.
CCG	NHS Stockport Clinical Commissioning Group.
Cerebral meningioma	A meningioma is a tumor that arises from a layer of tissue (the meninges) that covers the brain and spine.
CKD3	Chronic Kidney Disease. A long-term condition where the kidneys don't work as well as they should.
CQC	Care Quality Commission.
DOLS	Deprivation of Liberty Safeguard are part of the Mental Capacity Act 2005. The safeguards aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom.
DNACPR	Do not attempt cardio pulmonary resuscitation.
DVT	Deep Vein Thrombosis is a condition where a blood clot forms in a vein. This is most common in a leg vein.
ECG	Electrocardiogram. A simple test that can be used to check the heart's rhythm and electrical activity.
GMP	Greater Manchester Police.
'The Guidance'	The British Medical Association, the Resuscitation Council [UK] and the Royal College of Nursing have issued guidance entitled 'Decisions relating to cardiopulmonary resuscitation'.
HCA1 & 2	Health Care Assistants.
Heimlich manoeuvre).	A process for delivering abdominal thrusts in a person who is choking.
Hypoxia	A deficiency of oxygen reaching the tissues of the body.
L&M Healthcare	The company that owns and operates Cherry Tree House.
IMCA	Independent Mental Capacity Advocate-are people who act as a legal safeguard for those who lack the capacity to make specific important decisions.
IMR	Individual Management Review.
MCA 2005	Mental Capacity Act 2005 The Mental Capacity Act 2005 is an Act of the Parliament of the United Kingdom applying to England and Wales. Its primary purpose is to provide a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves.
N1 & 2	Nurses.
NWAS	North West Ambulance Service.
PM1	Paramedic.

Respiratory arrest	a condition that exists at any point a patient stops breathing or is ineffectively breathing. It often occurs at the same time as cardiac arrest, but not always.
SALT	Speech and Language Therapist-can provide an assessment of a patient's swallowing abilities.
SAR	Safeguarding Adult Review.
SSAB	Stockport Safeguarding Adult Board.
'The unified policy'	In the North West NHS area a Unified DNACPR Adult Policy was adopted in 2014 and applies to all of the multidisciplinary health, social and tertiary care teams involved in patient care across the range of settings within the North West area.
Vascular dementia	A common type of dementia caused by reduced blood flow to the brain. Dementia is the name for problems with mental abilities caused by gradual changes and damage in the brain.

APPENDIX A

SAFEGUARDING ADULT REVIEW CRITERIA

1. Section 44 Care Act 2014

Safeguarding adults reviews

(1) An SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) condition 1 or 2 is met.

(2) Condition 1 is met if—

(a) the adult has died, and

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

(3) Condition 2 is met if—

(a) the adult is still alive, and

(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

(4) An SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

APPENDIX B

SAFEGUARDING ADULT REVIEW PANEL MEMBERSHIP

Role	Agency
Business Support Officer	SSAB
SAR Author	Independent
Safeguarding Practitioner	NWAS
Director of Operations	Adult Social Care, SMBC
Named Nurse for Safeguarding	Pennine Care NHS Foundation Trust
General Practitioner	Designated Doctor for Safeguarding
SAR Panel Chair	Independent
Hospital Inspections Team	Care Quality Commission [CQC]
Service Manager	Safeguarding Adults Team, SMBC
Operations & Development Manager	Advocacy Services, Together Trust
Head of Safeguarding	NHS Stockport Clinical Commissioning Group [CCG]
Police Coroner's Officer	Greater Manchester Police [GMP]
Named Nurse Adult Safeguarding	Stockport NHS Foundation Trust
Detective Sergeant	Greater Manchester Police
Board Manager	Stockport Safeguarding Adult Board

Appendix C

Mental Capacity[34]

The Mental Capacity Act (MCA) is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment. It applies to people aged 16 and over. It covers decisions about day-to-day things like what to wear or what to buy for the weekly shop, or serious life-changing decisions like whether to move into a care home or have major surgery. Examples of people who may lack capacity include those with:

- dementia
- a severe learning disability
- a brain injury
- a mental health illness
- a stroke
- unconsciousness caused by an anaesthetic or sudden accident

But just because a person has one of these health conditions doesn't necessarily mean they lack the capacity to make a specific decision. Someone can lack capacity to make some decisions (for example, to decide on complex financial issues) but still have the capacity to make other decisions (for example, to decide what items to buy at the local shop). The MCA says:

- assume a person has the capacity to make a decision themselves, unless it's proved otherwise;
- wherever possible, help people to make their own decisions;
- don't treat a person as lacking the capacity to make a decision just because they make an unwise decision;
- if you make a decision for someone who doesn't have capacity, it must be in their best interests;
- treatment and care provided to someone who lacks capacity should be the least restrictive of their basic rights and freedoms.

The MCA also allows people to express their preferences for care and treatment, and to appoint a trusted person to make a decision on their behalf should they lack capacity in the future.

People should also be provided with an independent advocate, who will support them to make decisions in certain situations, such as serious treatment or where the individual might have significant restrictions placed on their freedom and rights in their best interests.

[34] https://www.nhs.uk/conditions/social-care-and-support/mental-capacity/

Appendix D

Transcript of 999 telephone call to NWAS

Patient: Mrs Grant

Incident Date: 28/09/2017

Incident Number: 17740404

Our Reference: INQ/NC/12464

Time of Call: 12:43:20

Length of Call: 00:04:53

Location of Incident: Cherry Tree House, Compstall Road, Romiley Stockport, Greater Manchester

EMD: Ambulance is the patient breathing?

Caller 1: Erm she's choking at the moment

EMD: Is she breathing?

Caller 1: Yeah she's breathing

EMD: Is the patient conscious?

Caller 1: No I don't, no, I'm in the office and 2 nurses are with her so I don't, I don't know

EMD: Isn't aware if the patient awake, ok. Is the breathing noisy?

Caller 1: Er *background talking: is the breathing noisy?*

Right I'll pass you on to the nurse

Caller 2: Hello?

EMD: Hello is the patient conscious?

Caller 2: Erm she's semi-conscious, I think she's aspirated on a tablet

EMD: Is she awake at the moment?

Caller 2: Yeah

EMD: Yeah

Caller 2: Yeah, she's cyanosed though erm and she's struggling

EMD: What's the address of the emergency please?

Caller 2: Its erm Cherry Tree House

EMD: Yep

Caller 2: Erm, it's a care home, Compstall Road, Romiley

EMD: Ok, is it 167 Compstall Road?

Caller 2: It is yeah

EMD: Ok tell me exactly what happened

Caller 2: Basically erm I've just come on site and the carer has just come in and said she looks like she is struggling, choking, erm and I've just gone in, she is cyanosed and erm her breathing is quite laboured

EMD: Ok

Caller 2: Erm and she's losing consciousness, she needs some oxygen

EMD: Are you with her now?

Caller 2: I am yeah

EMD: How old is she?

Caller 2: Erm she's got a DNR in place as well also, she's in her 80s

EMD: I'm just putting this information in for you now

Caller 2: Ok

EMD: Is she breathing or coughing at all?

Caller 2: Erm she's not able to cough
background talking

Erm no she's not able to cough

EMD: Is she breathing at the moment?

Caller 2: She is breathing yeah

EMD: Ok, do not slap her on the back ok?

Caller 2: Yep

EMD: Is she completely alert?

Caller 2: Erm she's closing her eyes, she's going drowsy

EMD: Ok. What did she choke on?

Caller 2: It looks like a tablet or I don't know I've just actually walked in the building, I'm just the unit manager here and the registered nurse

EMD: Right ok. I'm organising help for you now, stay on the line and I'll tell you exactly what to do next ok?

Caller 2: Yep

EMD: Do not slap her on the back.

Caller 2: Yep

EMD: Ok. Are you right by her now?

Caller 2: Erm I'm not I'm in the office, there's 3 people with her

EMD: Right ok. Can she breathe at all?

Caller 2: She is breathing but its very erm wet

EMD: Right

Caller 2: It sounds wet

EMD: Ok just bear with me I'm just putting this information in for you now ok

Caller 2: No problem

EMD: Just watch her very closely and don't slap her on the back

Caller 2: Ok

EMD: If she starts wheezing, making funny noises or becomes unconscious tell me immediately and tell me when the ambulance crew is right with her. What's her name please?

Caller 2: Just bear with me, someone who has been with her a second can give you a bit more info one minute

Caller 3: Hello?

EMD: Hello, what's her name please?

Caller 3: The patient's name?

EMD: Yes please

Caller 3: Mrs Grant

EMD: What's her date of birth please?

Caller 3: Oh right sorry, erm, date of birth, date of birth. It's the 8th of the 12th 1923

EMD: Thank you. And what's your name please?

Caller 3: My name is Loreal

EMD: That lady was just explaining she may have choked on tablets, is that right?

Caller 3: Er no, that was this morning she had struggled, difficulties swallowing her tablets but she's just been assisted with her dinner, I think she's aspirated

EMD: Right ok.

Ok, just keep watching her very closely and don't slap her on the back

Caller 3: I'm not actually in the room with her, the phone is in the office

EMD: Are you able to get the phone to her at all?

Caller 3: Erm no but if, could you phone me back on a mobile number if I give you that?

EMD: Yeah that's fine what is it please?

Caller 3: Just bear with me, erm it is 07

EMD: Yep

Caller 3: 925

EMD: Yep

Caller 3: 729

EMD: Yep

Caller 3: 831

EMD: And if you could just repeat that just to make sure I've got it right

Caller 3: 07

EMD: Yep

Caller 3: 925

EMD: Yep

Caller 3: 729

EMD: Yep

Caller 3: 831

EMD: Ok, I'll give you a call back on that number ok?

Caller 3: Thank you

EMD: Take care bye

Call back

Caller 3: Hello?

EMD: Hello it’s the ambulance service

Caller 3: Hi

EMD: Hiya, is she still breathing at the moment?

Caller 3: Erm yeah

EMD: Yeah ok

Caller 3: Really struggling

EMD: Ok

Caller 3: And she’s blue

EMD: Right ok. We’ll assess her breathing ok, I want you to say now every single time she takes a breath in starting immediately

Caller 3: Right

Now

EMD: Next one

Caller 3: She’s stopped

EMD: She’s stopped?

Caller 3: Yeah

EMD: Ok. Can she breathe at all?

Caller 3: No there’s no breathe

EMD: No, ok

Caller 3: Her eyes are still moving though

EMD: Ok. Is she standing, sitting or lying down?

Caller 3: She’s sat up in bed

EMD: She’s sat up? Ok

Caller 3: Yeah

Now

EMD: Oh, has she started breathing again?

Caller 3: Yeah

Now

EMD: Next one

Caller 3: Now

EMD: Next one

Caller 3: Now

EMD: Next one

Caller 3: Now

EMD: Next one

Caller 3: Now

EMD: Ok thank you

Caller 3: Now, do you want me to keep going?

EMD: No that’s fine thank you

Caller 3: No? Ok

EMD: Just let me know if anything else changes ok?

Caller 3: I will do

Caller 3: *background talking*

Right it’s stopped again

EMD: Right ok

Ok, standing near

Caller 3: Now

EMD: Ok

Caller 3: Now, it’s started again

EMD: She’s started again, ok

Caller 3: Yep

background talking

Would you like us to do any suction on Joan?

EMD: Erm just bear with me, I’ll just double check for you

Caller 3: Ok thank you

background talking

EMD: Er we can only advice for you to do what you would normally do in these situations we can't give any advice like that I'm afraid, if that's something you would normally do then by all means

Caller 3: Right well the Paramedics are here now anyway

EMD: Oh right ok, let me know when they are right with Joan

Caller 3: Yeah I will do

background talking

She's stopped again

EMD: Ok. If you stand or kneel behind her and put your arms around her waist, make a fist and grasp it with your other hand just above the belly button, be sure you are below the ribs and the breast bone

Caller 3: Yep

EMD: In one quick motion jerk hard, up and into the stomach, keep doing it until she can breathe, if she becomes unconscious tell me immediately

Caller 3: Ok

EMD: Can she breathe at all?

Caller 3: She's breathing a bit yeah

EMD: She's breathing a bit now ok, alright, just watch her very closely and don't slap her on the back alright? If she starts wheezing, making funny noises or becomes unconscious tell me immediately and just tell me when the ambulance crew is right with her ok?

Caller 3: I will do yeah

Background talking

Caller 3: Ok Paramedics are here

EMD: Alright I'll leave you with them ok?

Caller 3: Ok thank you very much

EMD: Take care, bye

Caller 3: Thank you bye