ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. HC One (care of LA Law Solicitors)**
1	**CORONER** I am Jane Gillespie, assistant coroner, for the coroner area of Nottinghamshire
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 03.04.2018 I commenced an investigation into the death of George Goldby, aged 63. The investigation concluded at the end of the inquest on 11.04.2018. The conclusion of the inquest was natural causes contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** George Goldby was admitted to Stoneyford Care Home on 31.08.2011. He had a medical history of hypertension, hypercholesterolemia, type II diabetes mellitus, transient cerebral ischaemia, cerebral atrophy, frontotemporal dementia and epilepsy. Mr Goldby was fully dependent on staff to meet his personal care needs, provide his medication and provide him with nutrition and fluids. On 22.10.14 Mr Goldby was assessed by [redacted], Speech and Language Therapist who recommended the following: - One to one supervision at mealtimes to prompt swallowing/focus to task - Normal diet although chewy meat items to be pureed as a means of reducing the length of the oral phase - Thin fluids On 04.10.16 an unknown care assistant completed a choking risk assessment in respect of Mr Goldby and arrived at a high risk score of 80. This was not verified by a nurse and did not result in a re-referral to SALT, nor to a review of Mr Goldby's care plan or dietary requirements. On 26.12.16 Mr Goldby choked during a mealtime and paramedics were called. He was not taken to hospital as he had recovered and the paramedics left at 2.06pm. Thereafter Mr Goldby was given chocolate bars, sandwiches and biscuits to eat. The choking incident was not entered onto Datix, nor was an incident and accident report completed. This incident did not, therefore, result in a re-referral to SALT or to a review of Mr Goldby's care plan or dietary requirements. It was found during the inquest that a choking risk assessment was completed on 02.02.17 which resulted in a high risk score of 54. No re-referral was made to SALT at the time, nor was Mr Goldby's care plan reviewed or dietary requirements considered. On 20.03.17 Mr Goldby choked on a sandwich. He was taken to hospital and died on 24.03.17. Following a post mortem examination the case of death was 1a. Aspiration Pneumonia 1b. Choking 1c. Dementia. Mr Goldby's SALT recommendations were not being adhered to on either occasion when he choked, nor was the SALT assessment on his file when it was seized and sealed at the time of his death. There were three missed opportunities to re-refer Mr Goldby to

	SALT and to review his care plan and dietary requirements. At the time of his death, none of the staff who gave evidence at the inquest were aware of a SALT assessment, the needs for one to one supervision or any specific dietary requirements.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – (1) The nursing home staff were unaware of the SALT recommendations regarding Mr Goldby's need for one to one supervision and dietary requirements. (2) Mr Goldby's SALT recommendations were not being adhered to on 26.12.16 when he choked and recovered, nor on 20.03.17 when he choked again, directly leading to his death. Mr Goldby was not supervised one to one during his mealtimes. (3) There were three missed opportunities to re-refer Mr Goldby to SALT and to review his care plan and dietary requirements. (4) The choking incident on 26.12.16 was not reported in line with Stoneyford's internal policy. (5) The care plan records and in particular, the choking risk assessments in respect of Mr Goldby were inadequately completed and record keeping has been incomplete and/or wholly disorganised. (6) The SALT assessment in respect of Mr Goldby had been archived and was not present on his care plan file at the time of his death. (7) Staff at the care home remain unaware of how many residents are at high risk of choking and the need for supervision. (8) Between 19.09.17 and 18.10.17 three separate independent professionals observed residents at high risk of choking eating alone, without supervision. (9) On 05.04.18 a reviewing officer from Nottinghamshire Safeguarding Team attended at the home to do a spot check and reviewed 4 files. That check revealed a choking risk assessment in respect of one of those residents which was said by the officer to be inadequate, out of date and not fit for purpose. (10) Stoneyford care home currently has a CQC rating of inadequate, is in special measures and has a current restriction in place regarding the admission of any further residents. (11) Stoneyford care home has had a high turnover of managerial staff in the past year and this has resulted in a lack of consistency and stability. The role of home manager has yet to be permanently filled.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/or your organisation have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 06.06.18. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.

8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: [redacted] – Mr Goldby's wife Nottinghamshire County Council Older Adults Safeguarding Team Care Quality Commission Clinical Commissioning Group [redacted] Previous Deputy Manager of Stoneyford Care Home [redacted]; Previous Area Operations Director of HC One Nursing and Midwifery Council I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**11.04.2018** **Miss Jane Gillespie**