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Coroner ME Hassell
HM Senior Coroner
Inner North London
St Pancras Coroner's Court
Camley Street
London N1C 4PP

BY EMAIL ONLY

10 June 2022

Dear Ms Hassell,

Inquest touching the death of Cristofaro Priolo

Response to the Regulation 28 Report – Action to Prevent Future Deaths

We write in response to your Regulation 28 Prevention of Future Deaths Report dated 11 May 2022, issued following conclusion of the inquest into the death of Cristofaro Priolo.

We would like to express once again how saddened we were by Mr Priolo's death and extend our deepest condolences to Mr Priolo's family.

Background

Mr Priolo passed away on 25 November 2020, following an incident at The Highgate Care Home, when he choked whilst being assisted to eat his evening meal. This was almost 18 months ago, and at the time, The Highgate moved quickly and took action to investigate and identify what had happened and why. This investigation was carried out by an investigator who, whilst being employed by Bupa, was independent of The Highgate. The investigation was revisited in early 2022, when further evidence was disclosed to Bupa and Mr Priolo's family in January 2022, ahead of the inquest. That evidence related to photographic evidence of the size and form of the cauliflower which Mr Priolo had eaten prior to choking.

Actions taken immediately following Mr Priolo's death

We wish to assure you that The Highgate took immediate action following Mr Priolo's death in November 2020 and has continued to improve in the areas highlighted in your Regulation 28 report since that time.

During the inquest, evidence was noted and heard, both from [redacted], who is the current Managing Director for the region, and [redacted], the home manager, as to the actions taken and improvements made at The Highgate since Mr Priolo's death, and we would refer you generally to their statements. The improvements and actions taken were overseen and checked by the Regional Director, [redacted]. Ms [redacted] had retired by the time of the inquest; however, Mr Smith was able to support the coroners' inquest having reviewed and agreed with those matters set out in Ms [redacted] statement.

The actions taken following the incident included:

- Training around Basic Life Support ("BLS" – the content of which includes addressing and dealing with choking incidents and CPR) and DNACPRs. This training involved an online/classroom based training session, as well as a practical session, where learners are practically assessed, and are not deemed competent until the trainer is satisfied that a learner is competent. We are mindful of your on-going concerns in relation to those nurses who gave evidence during the inquest, and we have said more on this point below – see *"concerns 3, 4 & 5"*, below.

- The role of "Mealtime Champion" was strengthened in the Highgate. The person fulfilling this role in the Highgate assists with the mealtime experience of residents and ensures that any di etary

requirements are observed and adhered to, by referring staff to the Speech and Language Therapy ("SaLT") team recommendation folder. This is a folder which is kept on each floor of the home, and contains additional information for all those residents who have been referred to the local SaLT team. This process has been embedded in the home.

The role of Mealtime Champion generally is included and defined within our Mealtime Experience document, which applies to all our care homes. As a general point, this role will reinforced and strengthened throughout our portfolio. The Mealtime Champion is defined in the document as being someone who is in charge of coordinating the mealtime experience for residents, and actively supervises the meal service. They need to ensure that residents receive the appropriate levels of nutrition, hydration and supervision, to avoid instances such as choking.

- All Choking Risk Assessments in residents' care plans were checked for accuracy immediately after the incident. This review was also verified by a visiting SaLT team therapist who confirmed the accuracy of information. This information is checked for all new residents during a care plan audit which is carried out within 72 hours of any resident being admitted into the building.

Outstanding concerns raised in Regulation 28 Report

Whilst you recognised the work which had been completed since the incident, you identified matters giving rise to concern, and you identified those concerns as training and audit.

You identified:

- The food (cauliflower) prepared for Mr Priolo should have been prepared properly for him.
- Mr Priolo's carers were never assessed when they were feeding him
- Staff, including qualified nursing staff, failed to give appropriate first aid and some staff, whilst giving evidence in court, were unable to describe the correct treatment for choking
- Nursing staff failed to recognise that Mr Priolo had suffered a cardiac arrest and then failed to attempt CPR.
- Difficulties in giving chest compressions may be reduced by frequent training.

Further and planned improvements

Having discussed the evidence given during the inquest, having regard to further investigations and after considering the concerns you raised in your report, we have identified further areas for improvement against each of your concerns, which I set out below.

Concern 1 - The food (cauliflower) prepared for Mr Priolo should have been prepared properly for him.

1. Bupa will implement a process to ensure food is quality assured prior to leaving the kitchen. This will be clearly described in our HACCP (Hazard Analysis and Critical Control Point) policy and documented next to the temperature checks within our standard paperwork. This new process will ensure that all food leaves the kitchen, a) at the right temperature and b) cooked thoroughly or the correct consistency. This would address and identify any repeat of undercooked food leaving the kitchen. This process will not be unique to the Highgate, it will be adopted UK wide across our portfolio.

2. A review of the HACCP policy, Nutrition and Weight Management policy, Mealtime Experience Standards, and associated training such as the International Dysphasia Diet Standardisation Initiative (IDDSI) will take place to ensure the actions described in this response are reflected in policy and training. This will include a review of induction material (Nutrition and Hydration) to ensure staff are taught how to assist residents with dietary intake in a safe way applicable to their needs.

   The review of the HACCP policy is targeted to complete by the end of June 2022. The IDDSI training review is already being progressed.

3. Bupa, in collaboration with Robot Coupe, will develop a suite of short videos, targeted to film in July 2022, on each of the IDDSI descriptors levels. This should be completed by the end of August 2022 and will be made available across the organisation and rolled out to employees subject to their roles. The Mealtime Experience document (referred to earlier in this response) will be reviewed in line with the IDDSI work we are planning and will be updated once the videos have been produced.

4. The Resident Mealtime Form (completed by the nursing and care team at the point of a resident's admission and used by the catering team) will be enforced. This will ensure that the existing process is operating effectively. This form is designed to capture resident specific information such as allergies, modified diet requirements or specific cutlery required. The form is reviewed monthly or more frequently as required. At Highgate, a copy of this form is kept within the Home's SaLT folders, including the SaLT folder kept in the kitchen. The SaLT folder includes for each of the Home's residents: dietary information, the Resident Mealtime form, eating/drinking protocols, IDDSI recommendations for residents, recommendations/advice from SaLT, the IDDSI framework and guidance on this, and blank SaLT referral forms.

5. As we transition to PCS electronic care planning, this process will become digitised and visible centrally for scrutiny by all staff.

6. Bupa are currently implementing a new structure into its operation which we aim to have fully recruited and implemented by the end of October 2022; this target date is slightly longer than others, to take account of the recruitment process. The new structure will involve the Director of Hotel Services and Customer First reporting into the Care Services Operations Director. 'Customer First' is our new customer experiential learning and improvement training. This will be overseen by a newly appointed team to drive standards in customer services, including catering and diet. During this training, staff have the opportunity to assist each other with eating a simple food item. This allows them to immerse themselves in how this feels and how it can be improved by putting yourself in that person's shoes. The Hotel Services Manager will further develop new safety measures and improvements when the appointment is confirmed.

7. The Director of Hotel Services and Customer First will communicate with all Chef Managers and their teams and relay the lessons learned. This will ensure there is awareness across the business of what happened at The Highgate, how we can learn from this and what we have changed as a result of it. Our catering teams can then implement the new processes. We are also exploring ways of providing face to face training for our catering teams on the requirements of IDDSI and are making available frozen IDDSI accredited meals from our suppliers so that our services can access appropriately modified meals as a contingency.

Concern 2 - Mr Priolo's carers were never assessed when they were feeding him

8. We have asked for additional materials and a competency check to be added to the current Nutrition and Hydration training module and we will work with our Learning and Development team to ensure this happens.

   These additional materials will build on the existing training and will focus on key principles of how to feed someone safely, for example; posture and seating arrangements; likes/dislikes/preferences; adaptive equipment required for a resident's needs; reinforcing the requirement to check the resident's care plan prior to assisting someone to eat their food; ensuring the food is at the right temperature; that the consistency is applicable for the resident's needs and to understands the risks around choking.

We are strengthening and reinforcing the role of the Mealtime Champion, who provides oversight and surveillance of mealtimes and is available to guide staff.

Concerns 3, 4 & 5 - Staff, including qualified nursing staff, failed to give appropriate first aid and some staff, whilst giving evidence in court, were unable to describe the correct treatment for choking; Nursing staff failed to recognise that Mr Priolo had suffered a cardiac arrest and then failed to attempt CPR; Difficulties in giving chest compressions may be reduced by frequent training

9. Our Internal Lead Inspector will attend training in Basic Life Support (BLS) to assess the quality and efficacy of the training provided internally by Bupa. To reassure you, our BLS and Emergency First Aid at Work trainers are all qualified and trained by external training providers. During this training our staff are evaluated and leave the classroom assessed as competent. This includes a practical assessment of delivery of chest compressions.

10. Given the concerns raised at inquest regarding the competence of some of The Highgate staff, we will ensure that those who remain within The Highgate are retrained, competent and confident to manage any further incidents in the future.

    We did, however, make enquiries with our Learning and Development team as to the training provided to staff at Highgate, including some of those who gave evidence at the inquest. We wanted to be sure that there had been no issue with their engagement or competency checks. The feedback from our trainer on the BLS training delivered at Highgate was that all delegates (which would include some of those who gave evidence during the inquest) had all passed first time and had a completed competency assessment on file, which confirmed, amongst other things, competent to deliver CPR and how to respond to a choking incident. However, the relevant staff will attend further training to ensure competency.

11. We also note your comments in relation to the frequency of training. At present, BLS is scheduled on an annual basis, although during the pandemic, there was a time during which practical assessments by trainers could not take place, due to measures put in place to comply with government guidance and infection prevention control measures. To the best of our knowledge, the frequency of our training is not out of step with other social care providers and our focus will be as outlined above, which is ensuring the quality and competency of our trainers, the content of our training and the competency checks, to ensure staff leave training confident and competent.

    We will, however, consider whether or not to implement more frequent competency checks, or opportunities to practice chest compressions. It should be kept in mind though that nurses have a professional obligation to take responsibility and ensure that they feel confident to carry out their role and maintain their competencies in line with NMC requirements.

In addition to the concerns you raised in your Regulation 28 Report, we wish to assure you that The Highgate and Bupa continue to foster a culture of continuous improvement and learning, to ensure that lessons learned are embedded. We have looked at our current process for cascading lessons learned and will produce further material in the form of recorded Teams meetings to allow people to cascade action arising from incidents in a different format.

We hope that this response provides assurance that The Highgate and Bupa as an organisation have taken extensive steps to learn lessons from Mr Priolo's tragic death. We have made significant improvements and will continue to ensure improvements and changes are embedded, addressing and mitigating risks to residents.

Yours sincerely,

[redacted]

[redacted]

[redacted]

[redacted]

Director of Risk and Governance, Care Services Risk & Governance

Operations Director, Care Services