Regulation 28: Prevention of Future Deaths report

Cristofaro PRIOLO (died 25.11.20)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Managing Director, London & East** **BUPA Care Services** **Highgate Care Home** **12 Hornsey Lane** **London N6 5LX**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 30 November 2020, one of my assistant coroners, Jonathan Stevens, commenced an investigation into the death of Cristofaro Priolo, aged 80 years. The investigation concluded at the end of the inquest today. I made a determination of death by neglect. It was recognised by those with care of Mr Priolo that he needed a soft diet of bite sized food. At approximately 5.30pm on 25 November 2020, he was fed cauliflower cheese in large pieces that were so undercooked they were almost raw. This caused him to choke. His medical cause of death was: 1a occlusion of the upper airway by food 2 fronto temporal lobar degeneration

4	**CIRCUMSTANCES OF THE DEATH** Cristofaro Priolo was an 80 year old man who had been diagnosed as having suffered a stroke and as having progressive Alzheimer's dementia. He was bed and chair bound, could not feed himself, was non verbal and needed to be cared for in a nursing home. Before his admission to Highgate BUPA Care home in March 2020, he was assessed as being at medium risk of choking, needing to be fed a modified diet of soft and bite sized food, in a quiet atmosphere without distractions, being allowed to finish one mouthful completely before he was offered the next. At approximately 5.30pm on 25 November 2020, staff fed him an evening meal of cauliflower cheese. He choked on it and died as a consequence. When it became apparent that Mr Priolo was in extremis, the ambulance service was called. However, nursing staff at the home failed to give appropriate first aid. When he suffered a cardiac arrest, they did not recognise this and they did not give cardiopulmonary resuscitation (CPR). After the arrival of paramedics, the nursing staff did attempt CPR, but ineffectively. That is likely to have been a result of panic and distress.
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 will occur unless action is taken. In the circumstances, it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. A BUPA internal investigation has already taken place and identified some learning points. However, there are matters outstanding around training and audit. Obviously, the cauliflower for Mr Priolo should have been prepared properly for him by the catering staff, but quite apart from that, Mr Priolo's carers were never assessed when they were feeding him. Whilst the carer who was feeding him when he choked knew that he needed small, soft mouthfuls that he should be allowed to swallow completely before offering the next, that is not what happened. He was fed a large quantity of cauliflower cheese, it seems relatively quickly, that was undercooked to the point of being almost raw, making it much too hard for him to swallow safely.

	Staff, including qualified nursing staff, then failed to give appropriate first aid. Even 18 months after the event when they were giving evidence in court this week – the inquest had been delayed to allow a police investigation – some staff were unable to describe the correct treatment for choking. Most significantly, nursing staff failed to recognise that Mr Priolo had suffered a cardiac arrest. They then failed to attempt CPR. After the arrival of paramedics, one member of nursing staff did attempt to give chest compressions, but these were ineffective. That is likely to be the result of panic and distress. These are common feelings in an emergency situation, but the risk of them overwhelming resuscitation efforts may be reduced by frequent appropriate training.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 11 July 2022. 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 following. • [redacted], wife of Cristofaro Priolo • Care Quality Commission for England • HHJ Thomas Teague QC, the Chief Coroner of England & Wales I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make

	representations to me, the coroner, at the time of your response, about the release or the publication of your response.	
9	**DATE** 11.05.22	**SIGNED BY SENIOR CORONER** *ME Hassell*