Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **The Oaks and Woodcroft Care Home** **2a Dereham Road, Matishall** **Dereham, NR20 3AA** **The Priory Group (Owner)**
1	**CORONER** I am JACQUELINE LAKE HM Senior Coroner for the coroner area of NORFOLK
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 06 July 2022 I commenced an investigation into the death of Peter Gary SEABY aged 63. The investigation concluded at the end of the inquest on 24 February 2023. **The medical cause of death was:** 1a) Aspiration Pneumonia 1b) 1c) 2) Down's Syndrome, Cirrhosis of the Liver, Cerebral Infarction. **The conclusion of the inquest was:** Mr Seaby died of aspiration pneumonia. Inadequate preparation of his lunchtime meal and inadequate supervision at his lunchtime meal possibly contributed to his death
4	**CIRCUMSTANCES OF THE DEATH** Peter Seaby was a resident at The Oaks and Woodcroft Care Home. Mr Seaby was assessed by a Speech and Language Therapist ["SALT"]. A SALT Care Plan was in place with regard to his nutrition which included specific requirements that he be given only soft, moist and mashed food, with two specific exceptions and that he was to be supervised throughout meals on a one-to-one basis with a ten minute gap between food and drink and for ten minutes afterwards. The Care Plan stated it was "essential" the Plan was adhered to and specifically provided that if the requirements were not adhered to, Mr Seaby was at risk of aspiration and asphyxiation "which are potentially life threatening". Evidence was heard that Mr Seaby was not always given food which complied with the Care Plan and he was not

	always provided with supervision in compliance with his Care Plan. On 21 May 2018, Mr Seaby's food at lunchtime was not prepared in accordance with the SALT Care Plan. Mr Seaby was not provided with the required one to one supervision during the lunchtime meal. During lunch Mr Seaby coughed while eating and brought some food back up. He cleared his throat and then appeared fine and finished the rest of his meal. At afternoon snack Mr Seaby brought up large amounts of phlegm and then coughed up anything he ate or drank. Mr Seaby was taken to see the General Practitioner by a member of staff who had not been with Mr Seaby during that day. No copy of Mr Seaby's Daily Record was shown to the General Practitioner. Mr Seaby was given a working diagnosis of gastric reflux and his medication was changed. At teatime, Mr Seaby coughed/vomited his medication and yoghurt and drink. Mr Seaby vomited phlegm on two more occasions. The 111 service was called at 20.53 hours. The out of hours Doctor was spoken to at 22.45 hours following which emergency services were contacted and Mr Seaby was taken to Norfolk and Norwich University Hospital where he died on 22 May 2018. Following post mortem examination a slice of carrot was found in Mr Seaby's throat.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. Many steps have been taken in the period following Mr Seaby's death. However there remain areas of concern The **MATTERS OF CONCERN** are as follows: 1. Evidence was heard at the inquest of the "informal approach" taken with regard to arrangements as to who would provide supervision of residents, including on a one to one basis and who would cook and prepare their meals, including those residents who were subject to a specific SALT dietary plan. Evidence was also heard of steps which have been put in place since Mr Seaby's death to provide written staff rotas for such matters, prepared by Team Leaders and Deputy Managers. However, despite these steps being taken, evidence was also heard at the inquest from staff, who continue to provide care at Oaks and Woodcroft Care Home, referring to providing care on an "informal basis" and that this "works". 2. It was not clear from the evidence that the staffing levels at Oaks and Woodcroft Care Home are sufficient to provide care for residents, including those requiring one to one supervision and supervision out of the Home and to cover individual activities 3. Mr Seaby died in 2018 and this is the second inquest into Mr Seaby's death. There has still been no internal review carried out following Mr Seaby's death which was unexpected. No Manager was present throughout the inquest and when some elements of evidence were put in dealing with Regulation 28 matters there was some surprise at some of the points raised and evidence heard during the course of the inquest.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 April 24, 2023. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: [redacted] represented by Hodge Jones & Allen, solicitor, Serjeants Inn, counsel NCC represented [redacted] CQC represented [redacted] I have also sent it to Healthwatch Norfolk who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response about the release or the publication of your response by the Chief Coroner.
9	**Dated: 27/02/2023** J Lake **Jacqueline LAKE** **Senior Coroner for Norfolk** County Hall Martineau Lane Norwich NR1 2DH