	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Northern Care Limited, trading as "ubu" Chief Operating Officer Windsor House, Cornwall Road, Harrogate, North Yorkshire HG1 2PW
1	**CORONER** I am Alan Anthony Wilson Senior Coroner for **Blackpool & Fylde**
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** The death of Steven Duquemin on at his home address was reported to me and I opened an investigation, which concluded by way of an inquest held on 28th June 2023. I determined that the medical cause of Mr. Duquemin's death was : **1 a Asphyxia** **1 b Airway obstruction** **1 c Inhalation of food material** In box 3 of the Record of Inquest I recorded as follows: *Steven Duquemin had a diagnosis of autism, epilepsy and what has been described as a mild to moderate learning disability. He has previously presented with depression and associated psychotic symptoms. Having last been seen in his flat at shortly after 8 pm on 28th August 2022, Steven Duquemin was found unresponsive in his chair in his flat at shortly after 9 am on 29th August 2022. He had been deceased for a number of hours. A subsequent post mortem examination revealed that he had been eating raw chicken at some point overnight when a significant piece of which had become stuck in his airway, that he began to choke, and he suffered a fatal lack of oxygen to the brain. Steven resided in accommodation which is a community – based, domiciliary – type property where personal care and support are provided for vulnerable people living independently. He received help with aspects of his daily care during the day, and*

	overnight he could seek assistance from a member of staff residing elsewhere in the building should he need to. The risk that Steven could choke on his food had not been fully appreciated, but from the available evidence it cannot be established that a fuller appreciation of the risk would have averted Steven's death. The conclusion of the Coroner was that Stephen died an **Accidental death.**
4	**CIRCUMSTANCES OF THE DEATH** In addition to the contents of section 3 above, the following is of note: • Steven Duquemin was a vulnerable man who died at a relatively young age. • During the day he had carers with him as he ate. He was at risk of choking and could eat erratically, even to the extent he may try to ingest non – food items. • At some point overnight he tried to ingest a large piece of raw chicken and choked. He could access food from his fridge at a time when no care staff were present. • He was not checked upon overnight – something a Service Manager told the court should have happened, but it cannot be said this would have altered the outcome. • The location of the flat in which Steven lived [redacted]
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. – • Entries in care records were inconsistent, some indicating Steven was not at risk of choking when he clearly was at such risk, and indeed one member of staff gave credible evidence that she had on one occasion have to use skills learned at some recent training to assist Steven after he overfilled his mouth with food. • My concern is quite straight-forward. I received evidence from a Service Manager. In my judgement, in the face of quite overwhelming evidence to the contrary – including a clear medical cause of death reported by the Pathologist - [redacted] continued to maintain that Steven had not been at risk of choking, and appeared to stand by entries in care records to the extent they indicated he had not been at risk of choking. • As I indicated at the conclusion of the inquest, it appeared to me that [redacted] did not feel anything different ought to have been done, and I formed the view that even if some measures were felt to be necessary to assist service users such as Steven, these were not necessarily going to be implemented with the speed which may be necessary to minimise potential risks. • I found [redacted] stance surprising, and I determined that there had been an under – appreciation of the level of risk. It creates an obvious risk to other service users

	when vulnerable people such as Steven are not appropriately assessed in terms of potential risks. It means the necessary preventative measures may not be put in place, and that their lives are at risk as a consequence. • The approach of a relatively senior member of the care staff can, of course, have an impact upon the approach adopted by other personnel and particularly regarding more junior staff.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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, and therefore on or before 16th September 2023 . I, the coroner, may extend the period further. 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: • Head of Adult Social Care, Lancashire County Council • Director of Adult Social Services, Blackpool 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	21/07/2023  Signature Alan Anthony Wilson Senior Coroner **Blackpool & Fylde**