IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of John LEE
A Regulation 28 Report – Action to Prevent Future Deaths

1	**THIS REPORT IS BEING SENT TO:** Angela Stevenson Chief Executive Surrey and Sussex Healthcare NHS Trust Trust Headquarters East Surrey Hospital Canada Avenue Redhill RH1 5RH
2	**CORONER** Miss Anna Crawford, H.M. Assistant Coroner for Surrey
3	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
4	**INQUEST** An inquest into Mr Lee's death was opened on 8 December 2022. The inquest was resumed and concluded on 20 November 2023. The medical cause of Mr Lee's death was: 1a. Choking 2. Dementia With respect to where, when and how Mr Lee came by his death it was recorded at Box 3 of the Record of Inquest as follows:

Mr Lee was an 83 year old man with dementia who lived in a care home. On 17 August 2022 Mr Lee was admitted to East Surrey Hospital following a fall. By 31 August 2022 Mr Lee was medically fit for discharge, however, he remained in hospital while efforts were made to find him a more suitable care home. Whilst he was in hospital Mr Lee was found to have a newly impaired swallow, the primary cause of which was thought to be his worsening dementia, which placed him at risk of choking and aspiration.

On 1 September 2022 Mr Lee was assessed by the Speech and Language Team (SALT Team) as being suitable for normal consistency foods, however, a number of recommendations were put in place to minimise the risk of choking and aspiration. These included to monitor him closely whilst he was eating and to check his mouth after eating to locate and remove any food debris. This recommendation was made because dementia patients are known to be at risk of holding food in their mouths and forgetting to chew or swallow it, which presents a risk of subsequent choking.

On 2 September 2022 hospital staff did not complete Mr Lee's food chart from mid-morning onwards and, as such, it has not been possible to establish what and when Mr Lee ate on 2 September 2022, save for the fact that he ate breakfast. However, Mr Lee had food residue in his stomach at post-mortem, which is consistent with him having a eaten a further meal or meals after breakfast.

Overnight on 2-3 September 2022 Mr Lee was confused and agitated and repeatedly tried to get out bed. He remained agitated until approximately 3am when he settled down and went to sleep.

At approximately 5.30am he was found unresponsive and his death was formally declared by a doctor later that morning on 3 September 2022.

A post-mortem examination was conducted which found that Mr Lee had died due to choking on a piece of food.

It has not been possible to establish precisely when on 2 September 2022 Mr Lee ate the food that he subsequently choked on. However, having eaten it, he retained it in his mouth for a period of time before subsequently choking on it.

Had Mr Lee been closely monitored and provided with effective mouthcare on each occasion that he ate on 2 September 2022, in accordance with the SALT recommendations which were in place for him, he would not have choked and he would not have died

The inquest concluded with a short form conclusion of 'Accidental Death' together with the following short narrative conclusion:

	Mr Lee was not closely monitored or provided with effective mouth care whilst eating on 2 September 2022. Had he been closely monitored, and provided with effective mouth care thereafter, he would not have choked and died on 3 September 2022.
5	**CIRCUMSTANCES OF THE DEATH** During the course of the inquest the court heard evidence from [redacted] of the hospital's SALT team that it was standard practice for dementia patients to have their mouths checked after eating, in order to locate and remove any food debris. This is because dementia patients are known to be at risk of holding food in their mouths and forgetting to chew or swallow it, which presents a risk of subsequent choking. However, Mr Lee's mouth care records indicate that he had only received mouth care once daily during the entirety of his hospital stay. The Court is therefore concerned that there is a risk that dementia patients are not receiving mouth care on each occasion that they eat and that this presents a risk of future deaths.

6	**CORONER'S CONCERNS** The **MATTER OF CONCERN** is: The Court is concerned that there is a risk that dementia patients at the Trust are not receiving mouth care on each occasion that they eat and this presents a risk of future deaths.
7	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.
8	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise, you must explain why no action is proposed.
9	**COPIES** I have sent a copy of this report to the following: 1. Chief Coroner 2. Mr Lee's family

10	**Signed:** **ANNA CRAWFORD** **Anna Crawford** **H.M Assistant Coroner for Surrey** **Dated this 6th day of December 2023**