REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, Cygnet Health Care**
1	**CORONER** I am Dr Elizabeth Didcock, Assistant Coroner, for the coroner area of Nottinghamshire
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 the 23rd January 2022, I commenced an investigation into the death of Peter Angus Dickens. The investigation concluded at the end of the inquest on the 28th March 2024 The conclusion of the inquest was a narrative conclusion as follows: Peter Dickens died at Bassetlaw District General Hospital on 22.1.22, following an episode of choking on a sandwich at Beeches where he was a resident. He was vulnerable, with autism and severe learning disability, the subject of a Deprivation of Liberty Safeguard order. He required full one to one support for all his needs, including support at mealtimes, to prevent him over filling his mouth and eating too quickly. The choking episode led to airway obstruction and to his death. His risk of choking was known and was a real and imminent risk to his life- he had had previous known episodes of life threatening choking. The Eating and Drinking plan that was in place to reduce choking risk and ensure close one to one support at mealtimes, also set out the process for safe food preparation and that a two plate system should be used to control Peters speed of eating and to ensure he did not overfill his mouth. This Guidance was not followed on the afternoon of his death, and this led directly to the choking incident that led to his death. There was also non compliance with the Eating and Drinking guidance many times prior to the day of Peters death, there was a lack of oversight of compliance with the guidance by Beeches managerial and multidisciplinary team staff, and the guidance was not adapted to reflect Peters high level of stress at Beeches, and how this was affecting the care staff's ability to comply with the Eating and Drinking guidance. All these omissions in care made a more than minimal, negligible, or trivial contribution to his death. Peters death was contributed to by neglect
4	**CIRCUMSTANCES OF THE DEATH** Peter died at Bassetlaw District General Hospital on 22.1.22, following an episode of choking on a sandwich, at The Beeches, where he was a resident. Detailed findings as to how, by what means and in what broad circumstances he came by his death, are set out in a written Determination dated 28.3.24, appended to this Regulation 28 report.
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) The persistent lack of compliance by staff with Eating and Drinking guidelines- there remains a lack of understanding by Beeches management of the reasons for the lack of compliance- if not understood, it is difficult to rectify in the future b) The lack of recording of the specific strategies used at mealtimes when there is an Eating and Drinking guideline in place c) The Failure of management and the Multidisciplinary team to effectively monitor compliance with Eating and Drinking Guidance- I have no evidence before me that demonstrates improvement with this important issue d) Apparent failure to provide the level of support that was funded for Peter- the costings and support level were set out in his current care and support plan- the Beeches management team appeared unaware that he was funded for a total of 18 hours per day, which is broken down into 12 hours one to one support per day and 6 hours two to one support per day I am not reassured that necessary actions to address these serious issues identified are in place.
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, namely by the **2nd July 2024.** 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. For the avoidance of doubt, I will require a response from the Chief Executive of the Nottinghamshire Healthcare NHS Foundation Trust, to all three matters of concern, with collaboration with the Nottinghamshire Integrated Care Board to ensure a full response to the first matter. .
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: 1. [redacted], Parents of Peter

	2. Lincolnshire County Council 3. Care Quality Commission 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	**6th May 2024** **Dr E A Didcock**