MISS N PERSAUD
HER MAJESTY'S CORONER
EAST LONDON
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REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Ref:23586673

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] CEO of Serencroft, [redacted]
1	**CORONER** I am Nadia Persaud, Area Coroner for the coroner area of East London
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** On 3 July 2023 I commenced an investigation into the death of Richard Michael Fitzgerald (aged 71 years). The investigation concluded at the end of the inquest on the 2 July 2024. The conclusion of the inquest was a narrative conclusion: *Richard Fitzgerald died as a result of choking, whilst a resident in a nursing home. His death was contributed to by the absence of a full and robust care plan to minimise the known risk of choking.*

4	**CIRCUMSTANCES OF THE DEATH** Richard Fitzgerald suffered from Alzheimer's Dementia. He was admitted to Gable Court Care Home in October 2022. In March 2023 he suffered a choking episode and required admission to hospital. Following his discharge from hospital, he underwent a speech and language therapy (SALT) assessment. This assessment confirmed no organic swallow issue, but Mr Fitzgerald was at risk of choking due to him overfilling his mouth and due to him eating too quickly. A care plan was directed by the SALT team to minimise his risk of choking. The nutritional care plan in Gable Court was updated to include the SALT recommendations. Staff in the Care Home were aware of Mr Fitzgerald sometimes eating food outside of mealtimes; food that was not safely prepared for him. There is no evidence that this risk was brought to the attention of the SALT team. This risk of accessing food not safely prepared for him, was not assessed or managed by the care home staff. In addition, due to his dementia, Mr Fitzgerald did not always allow the close supervision that had been directed by the SALT team. On the morning of the 24 June 2023, Mr Fitzgerald had his breakfast in his bedroom. This was supervised by a senior carer. After finishing his breakfast, the senior carer was with another patient when she heard a wheezing sound. She found Mr Fitzgerald having difficulty in breathing and she pressed the emergency alarm at 0916. It is most likely that Mr Fitzgerald had accessed uncut food from the breakfast trolley. Members of the housekeeping staff immediately attended and attempted measures to clear the food blockage (backslaps and abdominal thrusts). After pressing the emergency buzzer a second time, more staff members attended. Abdominal thrusts were attempted by male care staff. The ambulance was called at 0917. During the call to the ambulance service, Mr Fitzgerald was having increased difficulty in breathing. Very shortly before the first paramedic's arrival, Mr Fitzgerald stopped breathing and had a very low oxygen saturation. The first paramedic arrived at his side by 0923/0924. Mr Fitzgerald was found to be in cardiac arrest. The care home staff were not providing any resuscitative measures when the paramedic arrived. The emergency policy in place required the care home staff to commence basic life support. This was not done. There is however no evidence, on the balance of probabilities, that this would have prevented Mr Fitzgerald's death. The paramedic team were able to remove the food blockage from the airway and they carried out advanced life support. They were able to achieve a return of spontaneous circulation and they transferred Mr Fitzgerald to King George Hospital. Sadly, the return of spontaneous circulation was not maintained. Resuscitation continued, but sadly, Mr Fitzgerald had suffered a catastrophic hypoxic brain injury. He passed away at King George Hospital on the 26 June 2023.
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: 1. The Care Home staff were aware that the SALT care plan could not be consistently followed in terms of close supervision, but did not discuss this with the SALT team to ensure that a contingency care plan could be put into place. 2. The risk of Mr Fitzgerald picking up unsafe food was known to staff, but was not incorporated into the choking risk assessment and risk management plan.

	3. The emergency protocol for choking was not followed by the staff in attendance on 24 June 2023 (including qualified nursing staff). 4. The Care Home's investigation lacked thoroughness and professional curiosity.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] 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 4 September 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the family of Richard Fitzgerald, the Care Quality Commission, London Borough of Redbridge (Safeguarding team), and the local Director of Public Health 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 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	**10 July 2024** Ms G N Persaud