THE BEACONSFIELD CORONER'S COURT

IN THE MATTER OF AN INQUEST TOUCHING THE DEATH OF

SHEILA ANN NICHOLLS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Mandeville Grange Nursing Home
1	**CORONER** I am Michael Walsh, HM Assistant Coroner, for the coroner area of Buckinghamshire
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. https://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 https://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** The inquest into the death of Ms Sheila Ann Nicholls, aged 80, was opened on 22nd November 2023. The investigation concluded at the end of the inquest on 23rd October 2024. The medical cause of death was: Ia Hypoxia Ib Food Bolus Obstruction of Upper Airway II Severe Ischaemic Heart Disease (Stented) The Narrative conclusion to the inquest was: Sheila choked on food during a short period of respite care, at Mandeville Grange Nursing Home on 19.11.2023. Information on Sheila's swallowing problem was provided to the nursing home staff by family members, but the nursing home's assessments and checklists and handovers either omitted or did not share that information or the risk it presented, with all relevant staff. Breakfast was therefore given to Sheila that did not take her swallowing problem into account. Sheila subsequently choked on toast, suffering hypoxia that led to a cardiac arrest and what was an otherwise avoidable death. Neglect contributed to the cause of death.
4	**CIRCUMSTANCES OF THE DEATH** Sheila died due to choking on food only a day after entering the nursing home on 18.11.2023 as a respite care resident. Her family warned the nursing home of Sheila's swallowing difficulties and a need for monitoring whilst eating and to avoid certain foods, but important information went unrecorded and was not shared between staff, resulting in Sheila being provided with food she should not have been given and/or should have been prepared differently.

	On 19.11.2023 Sheila was given breakfast on which she choked, requiring emergency assistance from staff, only one of whom had valid current life support training, and the emergency response included ineffective CPR. Sheila died from choking on the food provided.
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. – **Concerns directed to Mandeville Grange Nursing Home** CONCERNS Management and circulation of internal written policies: 1. Mandeville Grange Nursing Home considered several existing policies required improvement, and so they were rewritten following Sheila's death, some using template documents from a health and safety outsourcing website. However, some rewritten policies still included clauses that remained irrelevant to the nursing home (e.g. regarding 'oral suction devices'), and several policies remained undated and unsigned, and it was therefore far from clear which policies had been ratified and were in force; with poor version control overall. It was not always clear when policies had been written or by whom; when and by whom they had been reviewed; and if and when they were circulated, and to which staff members. It was also unclear from the evidence of staff members, whether policies were properly embedded and/or understood, and/or had been read by all staff, as there were no checklists confirming staff had read and understood the policies. At the time of the inquest, staff training on new policies was said to be ongoing, and planned staff competency assessments had yet to be arranged. Deficient management of internal policies creates a risk of death to future residents where there is an inability to verify and record that all policies: (a) are relevant to Mandeville Grange in the first instance; (b) have been ratified and are in force; (c) have been reviewed as required; and (d) have been circulated to all relevant staff, with confirmation of those policies having been read and understood. Training in emergency response: 2. At the time of Sheila's death, of the several staff members that responded to her choking emergency, only one staff member (nurse GC) had currently valid training in life support, but still undertook CPR ineffectively without being corrected by other staff. Evidence was also given that no simulated emergency drills were ever performed, and some staff were never aware their training had expired. Whilst nurse GC still works for Grange Mandeville Nursing Home, it is unclear how that nurse will be supported in their ability to provide an adequate emergency response, bearing in mind their existing training appears to have been insufficient. The deficiency in training and embedding that training, both generally for all staff, and for that specific nurse, creates a risk of death to residents should future emergencies arise. Investigating and learning from adverse incidents:

	3. Evidence was given of two internal investigations undertaken by Mandeville Grange management following Sheila's death, both of which failed to adequately consider significant matters. The investigations were performed by staff untrained in investigating adverse incidents. The inability to adequately investigate such matters creates a risk of death to future residents given deficiencies in care may not be identified or remedied in a timely manner. At the time of the inquest, the nursing home's expressed intention was to instruct an external person or organisation to investigate future unexpected or unnatural deaths.
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 in relation to the concerns above.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 5th March 2025. 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: 1. Sheila's son 2. Sheila's daughter 3. Mandeville Grange Nursing Home 4. [redacted], former clinical lead nurse at Mandeville Grange Nursing Home 5. [redacted], RGN, at Mandeville Grange Nursing Home I have also sent it to: the Care Quality Commission, who may find it useful or of interest. 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	**7th January 2025**  **Michael Walsh** HM Assistant Coroner Beaconsfield Coroner's Court