ANDREW HETHERINGTON
HM Senior Coroner for Northumberland

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Date: 29 July 2025 Case: [redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

Hillcare Group operators of Oaks Care Home, Blyth

Northumbria Healthcare NHS Foundatuon Trust - Speech and Language Therapy

CORONER

1 I am Mr Andrew Hetherington HM Senior Coroner for Northumberland

CORONER'S LEGAL POWERS

2 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

INVESTIGATION and INQUEST

3 On 7 March 2023 I commenced an investigation into the death of Joan WHITWORTH. The investigation concluded at the end of the inquest . The conclusion of the inquest was: Died in a care home as a result of choking caused by massive aspiration.

CIRCUMSTANCES OF THE DEATH

4 Joan Whitworth was a resident at the Oaks Care Home, Blyth. She was diagnosed with advanced dementia. She required support with daily living and had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order in place.

On 19 January 2023 Adult Social Care referred her to Speech and Language Therapy (SALT) due to concern about her swallowing and/or behaviour. The referral lacked pertinent information. The SALT assessment carried out on 21 February 2023 did not include direct observation of her eating or review of her care records. Instead the assessment was based on the verbal account of a member of care home

staff. She was assessed as Normal Diet IDDSI L7 easy chew and to avoid difficult textures. It is possible that had more comprehensive information been considered a modified diet or additional risk reduction measures could have been considered.

On 3 March 2023 within a ground floor dining room of Oaks Care Home, Blyth her meal was prepared in a way that did not comply with her diet plan. She began to experience symptoms of choking as a result of massive aspiration of which she was at risk of. The care assistant did not intervene immediately and instead sought help. Another member of staff arrived and provided back slaps and attempted abdominal thrusts that could not be completed as the deceased was in her wheelchair. The deceased became cyanosed and unresponsive. No CPR was undertaken due to the inaccurate understanding of a registered nurse and the policy in place did not differentiate between DNACPR and possible reversible conditions such as choking. Effective resuscitation would have required advanced airway suction due to the massive aspiration. The equipment was not available and is unlikely to have altered the outcome. She died within Oaks Care Home, Blyth on 3 March 2023 at approximately 14.49 hours.

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. –

[BRIEF SUMMARY OF MATTERS OF CONCERN]

TO NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST - SPEECH AND LANGUAGE THERAPY

1. Whilst pertinent information was not provided to SALT, I am concerned that at assessment on 21 February 2023 there was no reliance upon the information provided in the referral to SALT which identified a concern for her swallow, coughing, weight loss choking. Instead the assessment was based on the verbal account of a member of care home staff. There was no observation of the deceased eating and there was no inspection of her care records.

TO HILLCARE GROUP - OPERATORS OF OAKS CARE HOME, BLYTH

2. Basic Life Support and First Aid at Work

I am concerned that a Registered General Nurse and a Senior Care Assistant were not in date with their training in Basic Life Support and First Aid at Work. I am further concerned that it could not be confirmed if an Agency Care Worker was up to date with their training in Basic Life Support and First Aid at Work.

3. Training

I am concerned that a Senior Care Assistant could not recall having received any formal training in the preparation of Care Plans, no training on MUST or calculating BMI yet was completing care plans and documents. I am further concerned than when the Senior Care Assistant completed the Nutritional Risk Assessment, on three dates the deceased was identified as high risk yet there was no referral to the GP, dietician or consideration of referral to SALT. I am concerned that in the absence of training there was not an understanding of the assessment.

4. Agency staff - induction

I am concerned that an agency member of staff remained in the dining room and was last seen standing next to the alarm bell cord. The care assistant did not intervene immediately when the deceased showed signs of choking and instead sought help. I am further concerned that it could not be confirmed if the agency staff had undergone an induction.

5. Normal Diet IDDSI L7 easy chew and to avoid difficult textures.

I am concerned that a chef in evidence at the inquest was not aware that breaded fish was not a suitable food stuff in the diet identified for the deceased. I am concerned that other residents could be fed inappropriate food stuffs that are not in line with their identified diet plans.

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you

6 **Hillcare Group operators of Oaks Care Home, Blyth**

Northumbria Healthcare NHS Foundatuon Trust - Speech and Language Therapy have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by
7 23 September 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.

COPIES and PUBLICATION

I have sent a copy of my report to the following Interested Persons

The family of Joan Whitworth

8 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.

29 July 2025

9 Signature A. P. Hetherington

Andrew Hetherington HM Senior Coroner for Northumberland