



H M Assistant Coroner for Gloucestershire  
Ms Rebecca Ollivere

	<p><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO:</b></p> <p><b>The Directors of Oak Tree Mews Care Home</b> <b>The Manager at Oak Tree Mews Care Home</b></p>
1	<p><b>CORONER</b></p> <p>I am Rebecca Ollivere, Assistant Coroner for the coroner area of Gloucestershire</p>
2	<p><b>CORONER'S LEGAL POWERS</b></p> <p>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.</p>
3	<p><b>INVESTIGATION and INQUEST</b></p> <p>On 25<sup>th</sup> November 2024, an investigation was commenced into the death of Margaret Taylor. The investigation concluded at the end of the inquest on 12<sup>th</sup> August 2025. The conclusion of the inquest was as set out below.</p>
4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>Margaret (Maggie) Taylor was 80 years old and resided at Oak Tree Mews Care Home in Gloucestershire. She suffered with Dementia, and Dysphagia, and a Speech and Language Therapy (SALT) review, had identified her as a severe risk of choking. She was last assessed on 9<sup>th</sup> September 2024, and placed on a level 5 soft food diet and thickened fluids. Food was to be soft and mashed. No review of her SALT assessment was carried out in October 2024, however, she was taken off the level 5 diet and this communicated via a Whatsapp message to all staff at the care home. There does not appear to be any rationale for this decision, and it does not seem to be a decision taken following a proper assessment.</p> <p>On 8<sup>th</sup> November 2024, Maggie's husband took into the care home, a chicken wrap, which he fed to Maggie. The evidence I heard was that he believed that Maggie had been removed from the soft food diet. He also indicated that the food was not checked for suitability by the staff at the home. I heard that this is against the policy of the home, which indicates that all food should be checked by staff. Sadly, Maggie began choking on a piece of chicken, and despite the best efforts of all involved, and paramedics who attended, she could not be resuscitated, and died at 12.40pm on 8<sup>th</sup> November 2024.</p> <p>The conclusion of the Inquest was that Margaret died as the result of an Accident. It is not known whether had the staff checked the food brought in by Mr Taylor, it would have been highlighted as not suitable, as she had been taken off the soft food diet, and so it may well be that it would still have been allowed. Therefore, I cannot say that there would have been any difference to the outcome for Maggie in this case had the staff checked the food.</p>

5	<p><b><u>CORONER'S CONCERNS</u></b></p> <p>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.</p> <p>The <b>MATTERS OF CONCERN</b> are as follows. –</p> <ul style="list-style-type: none"> <li>- There was no documented rationale, or further SALT assessment, before Maggie was removed from the soft food diet</li> <li>- Food brought in by Maggie's husband was not checked for suitability by the staff at the home</li> </ul> <p>I am concerned that if important decisions are being taken without proper assessment by the SALT team, and the rationale for these decisions is not being properly documented, and if food is not being checked in accordance with policy, then there is a risk of future deaths.</p>
6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p>
7	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by <b>7<sup>th</sup> October 2025</b>. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:</p> <ul style="list-style-type: none"> <li>- Family</li> </ul> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p><b>Date 12<sup>th</sup> August 2025 Assistant Coroner Rebecca Ollivere</b></p>