Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Secretary of State for Health and Social Care** **2 NHS ENGLAND**
1	**CORONER** I am Hassan SHAH, Assistant Coroner for the coroner area of Northamptonshire
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 22 August 2025 I commenced an investigation into the death of Jane Ann FENWICK aged 62. The investigation concluded at the end of the inquest on 18 February 2026. The conclusion of the inquest was that: Mrs Jane Ann Fenwick died on 21 August 2025 at Kettering General Hospital as a result of choking on a piece of beef at her care home at Coach House, 2 George Hattersley Court. She had no teeth and did not wear her dentures. She had a tendency to rush her food and put too much in her mouth. On the day of the incident, the food did not follow Mrs Fenwick's preference for softer food. Her care plan identified a risk of choking.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Jane Ann Fenwick died on 21 August 2025 at Kettering General Hospital as a result of choking on a piece of beef at her care home at Coach House, 2 George Hattersley Court. She had no teeth and did not wear her dentures. She had a tendency to rush her food and put too much in her mouth. On the day of the incident, the food did not follow Mrs Fenwick's preference for softer food. Her care plan identified a risk of choking. The medical cause of death was:- 1a. Hypoxic brain injury 1b. Cardiac arrest 1c. Choking/asphyxia due to upper airway obstruction from food bolus A narrative conclusion was given as above.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) Mrs Fenwick:-

	a) had no teeth b) did not wear her dentures c) had a tendency to rush her food d) had a tendency to put too much in her mouth e) had poor posture and generally did not sit at a table to eat f) did not sit still g) was generally not supervised whilst eating (despite the care plan recommending she be observed while eating) h) had a preference for softer food i) had a care plan which identified a risk of choking Despite the above, Mrs Fenwick had not been referred to Speech and Language Therapy (SALT). The care home's evidence was that even if Mrs Fenwick had been referred to SALT, she would not have met their threshold for support and intervention on the basis that there had been no previous episodes of choking. The care home also said in evidence that the average wait for SALT support is 13 weeks. I have concerns regarding the threshold for intervention/support and the current waiting lists.
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 April 16, 2026. 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 **Brother of Ms Fenwick** **Voyage Care** 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 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 by the Chief Coroner.
9	**Dated: 19/02/2026** [redacted]

	Hassan SHAH **Assistant Coroner for** **Northamptonshire**