REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] **Manager, Cedar Care Home, Yelverton, Norwich NR14 7PB** 2. **Caring Homes Healthcare Group Limited, Bradbury House, 830 The Crescent, Colchester Business Park, Colchester, Essex CO4 9YG**
1	**CORONER** I am JOHANNA THOMPSON, Assistant Coroner, for the coroner area of NORFOLK
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 13 July 2015 I commenced an investigation into the death of PAMELA JOYCE THURSTON aged 78. The investigation concluded at the end of the inquest on 29 February 2016. The conclusion of the inquest was accidental death due to 1a) Bronchopneumonia; 2. Alzheimers Disease.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Thurston died at Norfolk and Norwich University Hospital on 7 July 2015 after choking on some toast she was given at Cedar Care Home in Yelverton, Norfolk two days earlier.
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 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. – Mrs Pamela Thurston was a resident at Cedar Care Home in Yelverton. She suffered from Alzheimers' dementia and required prompting in order to eat meals and also supervision in doing so. Approximately two weeks prior to her death, Mrs Thurston was found to have stored prune stones in her mouth and had to be encouraged to spit them out. This was reported to the Care Home Manager and thereafter she was given prunes with stones removed. Her care plan was not altered, but a note was made for the chef to this effect. The Care Home procedure for checking that residents had been fed at mealtimes was that the chef would tick off the residents on a list kept in the kitchen. The residents were given their evening meal at approximately 5pm, and breakfasts were served from approximately 8am onwards following the staff handover at that time from night to day shift. On the morning of 5 July 2015, Mrs Thurston had awoken early as was her tendency, and was sitting in the care home conservatory. At approximately 11am, one of the staff

	became aware that she had not been given any breakfast and a decision was made to give her some toast. This was given to Mrs Thurston who proceeded to eat the toast so quickly that it became stuck in her airway which caused her to choke. Attempts were made to remove the toast when the attention of the staff was drawn to this by another resident. The nurse on duty was in a position to observe Mrs Thurston, but did not directly supervise her in eating the toast. The nurse was unable to remove the toast from Mrs Thurston's airway. Her subsequent attempts at CPR were unsuccessful, and heart rhythm was not restored until the arrival of paramedics. Mrs Thurston developed bronchopneumonia as a consequence of the choking incident, and subsequently died on 7 July 2015 in hospital. It appears that Mrs Thurston ate the toast she had been given too quickly as a consequence of being hungry, having had no food since the previous evening approximately between 5pm and 6pm, being a period of around 17 hours. When given the toast, she was left to eat this without direct supervision. She choked on the toast, and died in hospital two days later.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 31 May 2016. 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: [redacted] (husband) I have also sent it to: • Care Quality Commission • Healthwatch Norfolk • Executive Director of Adult Social Services, Norfolk County Council 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	**Dated 29 March 2016** **SIGNED:** [signature] **Johanna Thompson**