Eastern Area of Greater London Coroners

MISS N PERSAUD
SENIOR CORONER

Walthamstow Coroner's Court Queens Road Walthamstow E17 8QP
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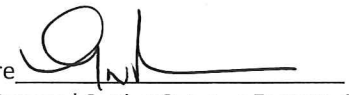
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: [redacted] Operational Director, Twinglobe Care Homes Ltd, Regional Office, 58-62 Abbey Road, Bush Hill Park, Enfield, EN1 2QN**
1	**CORONER** I am Miss N Persaud Senior Coroner for Eastern Area of Greater London
2	**CORONER'S 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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 17/02/2017, I commenced an investigation into the death of Ahmed Amin TABECHE. The investigation concluded at the end of the inquest 3rd May 2018. The conclusion of the jury at the inquest was: *The head injury sustained at St Ann's and the unsatisfactory assessments carried out during his stay at Aspray House contributed to the deterioration of his overall health and the insufficient guidance and supervision specifically relating to his feeding requirements all contributed to his death by choking.*
4	**CIRCUMSTANCES OF THE DEATH** Mr Tabeche had suffered a traumatic brain injury whilst an in-patient at St Ann's Hospital on or around 30 January 2014. His condition following the brain injury required full time care. He was admitted to Aspray Care Home on 2 March 2015. He was cared for on a unit with qualified nurses and care staff. He was blind, bedbound and required 2 carers to assist with personal care. He had suffered from swallowing dysfunction after the brain injury and required full assistance with feeding. The swallowing dysfunction had rendered him at risk of choking. The care plans and risk assessment in the Home recognised the risk of choking. The care plan also provided that "family and friends informed about it [swallowing difficulty] advice to give only soft pureed diet". There was no clear direction as to who could feed Mr Tabeche. There was no written record to confirm that visitors had been advised how to feed Mr Tabeche. On the 15 September 2016 Ahmed was being fed by one of his regular visitors. He was being fed vegetable soup, which contained pieces of vegetables. He began to cough whilst being fed the soup and care staff intervened. He was noted to be choking and the choking protocol was followed. Resuscitation was carried out by nursing staff and then paramedics. Sadly he did not respond. He passed away at the Care Home at 1344 on 15 September 2016. The cause of death provided by the pathologist was 1a choking in a man with old traumatic brain injury.
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: (1) The evidence given by the nursing staff and care staff who continue to work in the Care Home did not indicate a full understanding of the gravity of the risk of choking. Matters such as not causing offence to visitors or concern of turning the Home into a prison were quoted as reasons why food might not be fully checked. Care staff did not appear to appreciate that where a patient is at risk of choking, robust systems need to be in place to protect their lives. (2)I note that action has been taken by the Care Home to place more posters around the Home, informing visitors to notify the nurse in charge before giving food to the loved ones. I do not consider that this is sufficient to address the concerns that have arisen in this case. The visitor who had been feeding Mr Tabeche confirmed that he focussed fully on Mr Tabeche when he attended. He did not read posters which were located inside Mr Tabeche's room. He was not given any written information on the risk of choking; the type of food that Mr Tabeche should receive, or how he should be fed. More robust, written procedures around visitors and the provision of food may assist in providing a safer environment.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 6 July 2018. 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] (daughters). I have also sent a copy to the CQC and the Director of Public Health who may find it 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	11/05/2018 Signature  Miss N Persaud Senior Coroner **Eastern Area of Greater London**