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REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

Norman Barnes (died 17.11.2021)

	THIS REPORT IS BEING SENT TO: Ashley Gardens Care Centre, 419 Sutton Road, Maidstone, Kent Care Quality Commission
1.	**CORONER** I am Bina Patel, Area Coroner for the coroner area of Mid Kent & Medway.
2.	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3.	**INVESTIGATION and INQUEST** On 22nd November 2021 I commenced an investigation into the death of Norman Barnes who died, aged 67, on 17th November 2021 at Ashley Gardens Care Centre, 419 Sutton Road, Maidstone, Kent. The investigation concluded at the end of an inquest on 10th February 2022, conducted by me. I gave a narrative conclusion that: Norman Barnes died on the 17th November 2021 at Ashley Gardens Care Centre, 419 Sutton Road, Maidstone, Kent. He had choked on food whilst eating his lunch in the lounge of the care home. His lunch was not minced or

	moist as per the recommendation of his SALT assessment and devised care plan. This occurred on a background of Parkinson's disease which affected his swallow. The medical cause of death was: Ia. Inhalation of Food Ib. 1c II. Parkinson's Disease
4.	**CIRCUMSTANCES OF THE DEATH** Norman Barnes died on the 17th November 2021 at Ashley Gardens Care Centre, 419 Sutton Road, Maidstone, Kent. He had choked on food whilst eating his lunch in the lounge of the care home. His lunch was not minced or moist as per the recommendation of his SALT assessment and devised care plan. This occurred on a background of Parkinson's disease which affected his swallow.
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: Evidence was given by health care staff who were responsible for personal care which included service of and delivery of meals at Ashley Gardens Care Centre that: (1) Whilst they were aware Mr Barnes had a background of Parkinson's disease and this by its very nature often causes difficulties in chewing and swallowing, they were not aware of the contents of the care plan which reflected the recommendations of the SALT assessment for a 'moist and minced' diet for this resident. (2) Care Home staff who attend to patients who should be referring to key information contained within care plans and risk assessments to understand and effectively deliver a patient's daily needs and

	requirements had not and it was of concern to note that they were not fully aware of important information contained in these documents.
6.	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 **11th April 2022**. 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 following: • HHJ Thomas Teague QC, the Chief Coroner of England & Wales • [redacted] on behalf of the family of Norman Barnes • Care Quality Commission I am 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.	Signature:  Bina Patel, Area Coroner, Mid Kent & Medway 14th February 2022