C.G.BUTLER
SENIOR CORONER · BUCKINGHAMSHIRE

Inquest touching upon the death of Michael Walerjan Zawadzki

FINDINGS AND CONCLUSION

When Michael Zawadzki had a choking incident in July 2019 at Hamden Hall Care Centre, this was unexpected, and led to his being moved from a fork-mashable diet to pureed diet, which decision was confirmed following an assessment by the Speech and Language Therapy Team. Michael's care plan, including specific reference to his feeding regime, was amended and the daily feeding charts altered to reflect this new requirement.

This specific heightened vulnerability was a continuing risk for Michael from then on. The pureed diet was intended to mitigate that risk thereafter. Michael was not to be provided with or fed solid foods, nor even fork-mashable foods, at any point during the day or night. Were he to be provided with non-pureed food and were he to choke from the known and identified risk that would, in effect, be a "never event" for Michael, his family, the carers and the home.

Tragically that is what befell Michael on the evening of 24th October 2019 at Hamden Hall.

The key facts are clear from the evidence that we assessed over the three days of the Inquest.

1. Michael would attempt to eat what was provided to him and, due to his dementia, was not in a position to question suitability of the food.
2. The Hampden Hall policies included specified mealtimes – Breakfast, Lunch, Supper and Trolley Rounds.
3. There were basically two shifts each day – the day shift during which all the main meals would all be served to each resident and the night shift, during which two of the Trolley Rounds were scheduled to take place.
4. The evening Trolley Rounds included provision of drinks and snacks. The evidence from carers in person and from written statements is variable as to knowledge of Michael's requirements and what he was actually given by night carers, but it is clear that Michael was provided with cut up sandwiches on a number of occasions (three being mentioned in daily records) but with some greater regularity than this

Coroner's Office, 29 Windsor End, Beaconsfield, Buckinghamshire. HP9 2JJ
Tel: (01494) 475 505
Fax: (01494) 673 760
E Mail: coroners@buckinghamshire.gov.uk

indicated by some carer evidence. Sandwiches are, quite clearly, not part of a pureed diet.

5. The day shift utilised a signed record for meal times upon which were identified all the different residents' needs. From July 2019 Michael's need was identified as pureed diet. This day chart did not cover the night shift and thus, did not reflect any accountability for or ability to audit food provided during the night shift, notwithstanding that the Trolley Round was a recognised meal time.
6. It appears that a practice must have evolved whereby the leftover snacks, biscuits and sandwiches were used on the night Trolley Round for the residents. There is evidence that there was some sort of list, probably laminated, attached to the trolley which may have had some information about drinks, but this has never been located. In any event, other than a carer placing an entry in the daily records, there was no arrangement in place for a carer to sign for any specific food for any particular resident during the night shift.
7. There is evidence from floor staff of the presence of the day feeding charts in the kitchenette which were not used for the night shift but which did contain reference to Michael's pureed diet, in his case, and the other residents' needs.
8. Evidence from carers and nursing staff, particularly Ms Dadovici, was that the care plans for the residents were available for carers to read and that every day shift was handed over verbally to every night shift with any updates, changes and incidents. Ms Dadovici was clear in that for several weeks after Michael's diet had been changed, this was included in handover to carers. The care plan and daytime chart records had been changed to reflect this. Although the carer who ultimately fed Michael the sandwich appears to have been away for a period of time after the diet change, it seems to me implausible that she was not made aware of this at any point by any member of the night team during the following weeks and months and did not otherwise make herself aware of Michael's needs
9. It also appears to me to be a fundamental principle of the provision of any care to any resident by any carer that the carer understands all the elements of that care (including feeding requirements). It is inconceivable that care plans would not, at the very least, be read by a carer and knowledge refreshed after changes or periods of absence.
10. The care plan arrangements were an important part of the structure put in place by Hampden Hall to provide care to each of the residents. The staff were there to implement that care. The absence of continuity in signing for specific food

throughout each 24-hour period would be mitigated by knowledge of a resident's care plan.

11. It appears from a number of accounts that pressures on staff during the night shift did exist and there were numerous activities to be undertaken both from a nursing perspective and in relation to the provision of care every night. This reinforces the importance of carers having a full knowledge of each of the resident's needs based on the care plans so that the individual needs become second nature based on fact not on evolving unwritten practice.
12. The carer who fed Michael stated in her evidence that she had not read Michael's care plan and said that she had never discovered he was on pureed diet. She did, however, feel it was necessary to remain with Michael whilst he was eating so there must have been some perception of a risk of choking, but it is unclear to me upon what basis this was founded.
13. The carer indicated that on the night of 24th October 2019 she provided two quarters of a ham sandwich to Michael. She remained in the room for several minutes whilst he appeared to be chewing this, but left after he had taken the last piece of sandwich.
14. Another staff member appears to have seen Michael consuming the sandwich when she brought a drink whilst nobody else was then present with Michael
15. It is clear from the evidence of those who assisted when Michael was found unresponsive, that Michael had undigested sandwich in his mouth. He had sandwich further inside his throat which staff attempted to remove with suction, he had sandwich deeper down in his airway removed by laryngoscope by attending paramedics and he had a food bolus recovered by the pathologist at post mortem. In fact, there appears to be very little in gastric contents compared with all the evidence of food in the airways. Michael cannot have been giving any real indications that he was eating and swallowing the pieces of sandwich.
16. There is then a further period of time (which appears to be in the region of 10 to 20 minutes) between Michael last being seen and being found unresponsive, pale and blue. Emergency services were called at 20:48. It seems to me, on the balance of probabilities, that this timescale alone prevents any successful resuscitation by attending staff and subsequently the paramedics. The extent of obstruction of the airway and the time it subsequently took try to remove food at the home indicate those efforts, whilst fully justified as overriding any DNACPR, were always going to be futile. There was, in any event, more food obstructing Michael's airway only discovered at post mortem.

17. Michael died from obstruction of his airway – in other words he choked on the pieces of sandwich he had been given.
18. There was evidence from care staff of non-availability of pureed food at night. This should not be confused, in any way, with an understanding about each patient's needs. It appears to me that the manner in which the night Trolley Round had evolved (and I know not over what period) enabled availability of food to dictate what was offered rather than Michael's care plan.
19. The clear medical cause of death identified at post mortem was that Michael died as a result of acute upper airway obstruction (or choking) due to his dementia. Ischaemic Heart Disease was a contributory factor. There is no dispute about this.

I turn to completion of the Record of Inquest.

Looking at all these facts, there is no issue about Michael's identity. His full name, Michael Walerjan Zawadzki will be entered into Section 1 of the Record of Inquest and his full personal details will be included in Section 5 of the Record of Inquest as well as the papers for the Registrars.

The medical cause of death in Section 2 of the Record of Inquest and for the formal death certificates is: 1a Acute Upper Airway Obstruction (Choking); 1b Dementia. There is a contributory factor of Ischaemic Heart Disease recorded at 2.

The primary cause of death is entirely consistent with what was found at post mortem and all the evidence of the immediate circumstances of Michael's death.

In turning to the facts which support the answers to the questions, when, where and how Michael came by his death the position is equally clear. I shall enter the following in Section 3 of the Record of Inquest:

Michael Zawadzki was found unresponsive at around a quarter to nine on the evening of 24th October 2019 sitting up on his bed in his room at his place of residence. Michael had choked on pieces of a sandwich which had been provided to him by a carer on the night shift, notwithstanding that Michael had required a pureed diet since July 2019 following a

previous choking incident whilst on a fork-mashable diet. The details of Michael's diet were contained in his care plan and were also, on balance, likely to have been included in verbal handovers to night care staff for a period of time after the previous incident. The carer who provided the sandwich to Michael had not read Michael's care plan, although the carer was a permanent member of staff who regularly cared for Michael. This carer did not know Michael required a pureed diet. Michael's death was verified in his room by attending paramedics.

I now turn to the question of the conclusion to be entered in Section 4.

I have had regard to the submissions on behalf of Westgate for Hampden Hall, for South Central Ambulance Service, for Ms Dadovici and on behalf of Michael's family. The carer who provided Michael with the sandwich was not legally represented, but was clear and candid in evidence, and so I have exercised great care in reaching my conclusion.

I have also had regard to the guidance of the Chief Coroner in Guidance 17 and the guidance both on the application of Galbriath plus and the law applicable to requirements to be demonstrated on the balance of probabilities to reach a conclusion of unlawful killing, accident or misadventure or a narrative.

Although all facts are found only to the level of certainty that they are more likely than not the case, and each conclusion tested with the same level of certainty, it is still appropriate to consider the conclusion of unlawful killing first, as it carries with it significant gravity.

There are two areas that I look at here – the law in relation to Gross Negligence Manslaughter and the law in relation to Corporate Manslaughter.

The latest guidance on the Law issued by Chief Coroner reiterates the 6-part test to be satisfied by the facts on the balance of probabilities in relation to Gross Negligence Manslaughter:

(1) The defendant owed an existing duty of care to the victim.

It is clear to me that the individual carer was employed by Westgate in that role with appropriate care qualifications and owed an individual duty of care to Michael in relation to the various aspects of care provided to him on each shift worked. That included the provision of nutrition appropriate to Michael's specific, known and identified needs.

(2) The defendant negligently breached that duty of care.
It is equally clear to me that the carer had access to the policies of the employer, that Michael's care plan and records were available to read, that there were day shift records available also demonstrating Michael's feeding requirement and, since I favour the evidence of Ms Dadovici in this respect, that there were verbal handovers confirming Michael's change of regime for a period of time from July 2019. The carer stated she had not read Michael's care plan. In the absence of procuring information from elsewhere, not reading the plan was a fundamental issue which demonstrated that the carer was providing a particular type of food to Michael based on no actual knowledge of his care needs. This is a clear breach of the duty of care which rests with this particular carer.

(3) That breach of duty gave rise to an obvious and serious risk of death.
The rationale behind Michael being moved to purred diet demonstrates the clear and obvious risk of choking. Non-compliance with that feeding regime by offering the sandwich reintroduces the clear risk that Michael would choke again. The breach is inextricably linked with the risk.

(4) It was also reasonably foreseeable that the breach of that duty gave rise to a serious and obvious risk of death.
Given Michael's dementia and the prior choking incident it is entirely foreseeable that a choking incident would lead to obstruction of the airways which, if not addressed immediately, would probably cause his death. The breach is inextricably linked with a clear risk of death.

(5) The breach of that duty caused the death of the victim.
Michael was fed pieces of a sandwich, in breach of the duty of care owed by the carer to Michael flowing specifically from his nutritional requirements as documented in his care plan. His death was caused by the obstruction of his airway by pieces of that sandwich.

Coroner's Office, 29 Windsor End, Beaconsfield, Buckinghamshire. HP9 2JJ
Tel: (01494) 475 505
Fax: (01494) 673 760
E Mail: coroners@buckinghamshire.gov.uk

(6) The circumstances of the breach were truly exceptionally bad and so reprehensible as to justify the conclusion that it amounted to gross negligence and required criminal sanction.
The fact that Michael had a specific need, identified following an actual choking incident, which was documented, and which was the subject of a Speech and Language Therapy assessment meant that Michael's risk of choking on solid food was clear and properly identifiable to any carer providing care. The non-compliance by the carer with Michael's documented feeding regime was, on balance, as serious a breach as one could find and not reading the care plan is not a defence but reinforces the gravity of the situation. On the balance of probabilities the specific circumstances of this case fully justify a conclusion of unlawful killing on the basis that what came to pass amounted to gross negligence and would have led to criminal sanction (albeit that this court is not concerned with blame or liability).

As a final but important point, each of the 6 elements of Gross Negligence Manslaughter must be established on the balance of probabilities and must relate to one identifiable person (who must not be named) and may not be aggregated through the actions of a number of people. I find all these elements proven against the individual carer who provided Michael with the sandwich.

In conclusion, I find that in being given a sandwich in contravention of Michael's care plan by a carer who had not read Michael's care plan, and then in that carer not remaining with Michael until all of the sandwich had been swallowed, Michael choked to death and his death on balance of probabilities resulted from Gross Negligence Manslaughter. This entirely supports a finding of Unlawful Killing in this Inquest.

In reaching this conclusion, I find all the facts to be supportive of this. Further it is entirely reasonable and in the interest of justice that such a conclusion is reached notwithstanding that it flows from the actions of a single individual who was not legally represented at the Inquest. Lack of representation is not a reason to consider that this conclusion is unsafe in the Galbraith plus sense in this case.

Coroner's Office, 29 Windsor End, Beaconsfield, Buckinghamshire. HP9 2JJ
Tel: (01494) 475 505
Fax: (01494) 673 760
E Mail: coroners@buckinghamshire.gov.uk

I do not find the evidence of Ms Dadovici demonstrates any of the criteria for gross negligence manslaughter on its own or in addition to that of the carer. In this regard I favour the submissions on behalf of Ms Dadovici insofar as they specifically relate to her actions. I do not find that countersigning care notes which contained reference to sandwiches in any way approaches the level of severity required.

I do not find that any of the actions of any individual attending paramedic or those staff attempting to resuscitate Michael demonstrate any of the criteria for Gross Negligence Manslaughter. I favour the submissions on behalf of South Central Ambulance Service to the extent that they relate to attending ambulance staff.

I turn to the question of Corporate Manslaughter and the criteria to be satisfied to support a finding of unlawful killing on the balance of probabilities.

I mention again in brief the guidance on the Law from the Chief Coroner:

Corporate Manslaughter contrary to section 1 of the Corporate Manslaughter and Corporate Homicide Act 2007 (the 2007 Act) is a similar offence. It is committed by an organisation (or other body listed in the Act) if the way in which its activities are managed or organised causes a person's death and amounts to a gross breach of a relevant duty of care owed to the deceased.

Relevant duties of care under the law of negligence, such as a duty owed to the organisation's employees or as occupier of premises, are listed in section 2 of the 2007 Act. A breach of a duty of care is gross 'if the conduct … falls far below what can reasonably be expected of the organisation in the circumstances': section 1(4)(b) of the 2007 Act.

There are exceptions for particular organisations responding in emergency circumstances: section 6 of the 2007 Act.

I do not find that any of the actions of the ambulance service as a whole demonstrate any of the criteria for Corporate Manslaughter.

In relation to Hampden Hall, I do not agree with the submissions on behalf of Michael's family. There was a structure in place. It was ineffective in parts rather than grossly negligent. The conduct of Westgate cannot be said to have fallen far below a reasonably expected standard. Any system is operated by the staff and individuals. It clear in my finding that Gross Negligence Manslaughter is demonstrated on balance of probabilities based on the acts and omissions of one carer, on the particular facts of this case, that those acts and omissions undermine substantively the corporate position both practically and legally.

Westgate must be entitled to rely upon a carer signing for policies and training provided, although I do accept that initial training may not have met all the intended aims. This carer had been a full time employee for much longer than merely the period of initial training. Westgate would be entitled to place reliance upon that carer reading Michael's care plan from time to time and ensuring complete familiarity at all times with Michael's needs as well as other residents as part of the provision of care by that carer.

There is some evidence of staff being aware of Michael being fed sandwiches, and of some staff being aware of his feeding requirements, but no evidence of this being escalated by staff in an effective way to prevent this practice from continuing. This is a further mitigating factor from the corporate perspective.

Although there were clear concerns about how busy the night shift was and an inconsistency in the feeding regime at night compared with the day, the carer's knowledge of each resident for whom the carer was providing care was such an integral part of that care as to be the central and fundamental issue here.

For these reasons, whilst I maintain the position that the conclusion is unlawful killing, it is NOT on the basis of corporate manslaughter having been demonstrated in this case.

Having established this conclusion I do not need to consider accident or misadventure, although Michael's death was not intended.

Coroner's Office, 29 Windsor End, Beaconsfield, Buckinghamshire. HP9 2JJ
Tel: (01494) 475 505
Fax: (01494) 673 760
E Mail: coroners@buckinghamshire.gov.uk

Nor do I need to consider a rider of neglect with a conclusion of unlawful killing although I do think that since Michael's specific nutrition requirements were known and had been assessed, the failure to provide suitable food to meet that requirement would be regarded as a gross failure in relation to a basic need which led directly to his death. This was not a complex need in the slightest, and quite separate from negligence, about which I do not and should not venture an opinion at all, save to the extent that it is referred to in the context of the tests for unlawful killing.

In conclusion, I will enter "Unlawful Killing" in Section 4 of the Record of Inquest.

Let me turn, finally, to the question of a Report to Prevent Future Deaths.

The action taken against the carer removed the risk of facts I have found being repeated. I do intend to notify the CQC of the outcome of this Inquest by providing them with a copy of these findings and the Record of Inquest. It will be important for the evidence at this Inquest to be considered by relevant regulating bodies in relation to the future activities of the carer who was central to the issue in this case.

The introduction by Westgate of an entirely new electronic case management for the care staff eliminates the evolution of an unsafe practice in the hands of a particular individual and provides accountability and an auditing process.

As we heard from the evidence from Sita Foxon, Michael's death is a tragic event which has informed specific learning and continues to inform the teaching for staff going forward within Westgate and at Hamden Hall. It seems to be entirely appropriate that this remains the case some 3 or so years after Michael's tragic death.

I do not find that my duty to raise a Report to Prevent Future Deaths arises in this case.

Crispin Butler

9th March 2023

Coroner's Office, 29 Windsor End, Beaconsfield, Buckinghamshire. HP9 2JJ
Tel: (01494) 475 505
Fax: (01494) 673 760
E Mail: coroners@buckinghamshire.gov.uk