IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Gaenor Moore
A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: Invacare Rehabilitation Salter Labs Dolby Vivisol
1	**CORONER** Martin Fleming Assistant Coroner for Surrey
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009 paragraph 7, schedule 5 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 7/8/13 I opened the inquest into the death of Gaenor Moore who at the date of her death was 87 years old. The inquest was resumed and concluded on 17/11/13 and concluded on 19/11/13. I found that the cause of death to be: 1a – Exacerbation of chronic obstructive pulmonary disease I concluded with a narrative conclusion as follows: Gaenor Moore who had a history of Chronic Obstructive Pulmonary Disease and required the use of an oxygen concentrator with humidifier died on 27/7/13 at her residential care home in Woking. The cap to her humidifier was not properly engaged which prevented her receiving oxygen via her nasal cannula. It is found more likely than not that the lack of oxygen made less than a minimal contribution to her death and that she died from natural causes.

4	**CIRCUMSTANCES OF THE DEATH** Mrs Moore had a history of chronic obstructive pulmonary disease for which she required an oxygen concentrator along with an attached humidifier. On 27/7/13 at approximately 4.45pm a carer in her residential care home refilled the humidifier with water and left Mrs Moore using the nasal cannula. Subsequently at approximately 7pm when Mrs Moore activated the emergency button in her room, carers found her to be nauseas and breathless and shortly after, she deteriorated and collapsed and died notwithstanding attempts to revive her. It was subsequently found that the screw cap to the humidifier had not been properly engaged and that this prevented the oxygen flow to her cannula.
5	**<u>CORONER'S CONCERNS</u>** During the inquest the following concerns arose: - • The lack of oxygen flow to the nasal cannula as a result of the screw cap to the humidifier not being properly engaged. • Absence of a visual or audible alarm on concentrator machine (product number INV-IRC5PO2AWN) to indicate the loss of oxygen flow to the nasal cannula when the screw cap to the humidifier (manufactured by Salter Labs) was tightened and cross threaded. • Accompanying training and literature did not reference the implications to oxygen flow in the event of failing to properly engage the screw cap to the humidifier. I would ask that you consider giving further consideration to the equipment and accompanying information to ensure that there is no further repetition.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that Invacare Rehabilitation, Salter Labs and Dolby Vivosol has the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request.

	Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
8	**COPIES** • [redacted] • Greys Residential Care Home • MHRA • The Department of Health • Chief Coroner
9	**Signed: Martin Fleming** **DATED this 24th November 2014**