

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO: Westwood Homecare (North West) Limited</p>
1	<p>CORONER</p> <p>I am John Pollard, senior coroner, for the coroner area of South Manchester</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 10th October 2014 I commenced an investigation into the death of Walter Willows dob 19th December 1937. The investigation concluded on the 24th February 2015 and the conclusion was one of Accidental death. The medical cause of death was 1a asphyxia 1b Choking on food 11. Coronary Artery Atheroma</p>
4	<p>CIRCUMSTANCES OF THE DEATH On the 3rd October 2014 he was at his home address. He ate a crumpet and choked. This led him to asphyxiate.</p>
5	<p><u>CORONER'S CONCERNS</u></p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <p>During the course of the inquest hearing I was told, inter alia, that the Care Plans for such clients were reviewed on a three monthly basis. This included their specific feeding regimes. In the case of Mr Willows it was apparent that this should have been looked at far more frequently so as to adjust his diet to suit his swallowing ability. I took the view that these Plans (and especially that part relating to feeding) should be examined more frequently and it was within the power of yourselves to arrange for this to happen.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 5th August 2015. I, the coroner, may extend the period.</p>

	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	
	<p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely [REDACTED] (daughter of the deceased).</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>	
9	10.6.15	John Pollard, HM Senior Coroner