REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive – George Eliot Hospital**
1	**CORONER** I am S McGovern, senior coroner, for the coroner area of Warwickshire
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.
3	**INVESTIGATION and INQUEST** On 14 March 2016 I commenced an investigation into the death of Stanley SAMPEY 92 years old. The investigation concluded at the end of the inquest on 13 May 2016. The conclusion of the inquest was accidental death.
4	**CIRCUMSTANCES OF THE DEATH** Mr Sampey was an in-patient at George Eliot Hospital. While eating a meal in bed on 5 March 2016 he choked on a food bolus. While medical staff were dealing with this incident they attempted to suction Mr Sampey's airway. The wall mounted suction device was found not be working and when the crash trolley containing a portable suction unit arrived it was also not working,
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. There was no working available suction equipment on the Ward to manage the patient's airway at the time of the cardiac arrest. 2. There was a lack of any structured checking procedure in place to ensure working suction equipment on wards. 3. The battery on the portable suction unit was found to be flat and the checking procedure was incorrect.

	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you as Chief Executive of the Trust 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 13th July 2016. 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 (a) [redacted]–daughter of Mr Sampey 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	**18th May 2016** **Senior Coroner S McGovern** S McGovern