	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Department of Health.** **2. Care Quality Commission.**
1	**CORONER** I am Dr Peter Dean, senior coroner for the coroner area of Suffolk
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** At the conclusion of the inquest into the very sad death of ASHLEY ERNEST NOTSON, I recorded a conclusion of 'Accidental death'. The cause of death was found to be: 1a Hypoxic brain injury due to 1b Hypoxic cardiac arrest due to 1c Upper airway obstruction from inhalation of a foreign body, with Autistic spectrum disorder in Part II.
4	**CIRCUMSTANCES OF THE DEATH** Ashley Notson died in very tragic circumstances at the age of 55 after a period of time in hospital where he was taken after choking on a piece of meat at the care home in which he lived. Attempts to resuscitate him, including Heimlich manoeuvres, were conducted by a staff member on duty at the care home who had previously had training in first aid but, sadly, Mr Notson passed away from hypoxic brain injury resulting from the choking episode.
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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – The inquest heard that the law currently does not require care providers to ensure that carers in a care home have had first aid training. Fortunately, the carer on duty at the time of the incident was trained in first aid and did what he could to assist Ashley, but a similar situation could clearly arise in another care home without such a suitably trained carer present. The inquest also heard that, at this care home, all carers carry a mobile or portable telephone so that they can summon assistance if an incident occurs without having to leave the person they are looking after, but that this was not a legal requirement either.
6	**ACTION SHOULD BE TAKEN** Although appropriate assistance was given promptly here, despite the tragic outcome, it is clearly foreseeable that additional problems could occur in another care home if carers did not have first aid training or carry a mobile or portable telephone. To try to reduce the risk of future tragedies and fatalities occurring, I would ask CQC and the Department of Health to give consideration to amending the current legal framework to ensure that care staff are all suitably trained in first aid and carry mobile telephones with which they can summon immediate assistance if an incident occurs without having to leave the side of the person

	they are trying to assist.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by the 24th of August 2018. 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: Mr Notson's family. Similarly, you are 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.
9	**Dr Peter Dean** PDean **29-6-18**