REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28: REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO**: Brunswick Retirement Village, Station Road, Woodhouse, Sheffield
1	**CORONER** Tanyka Rawden, Assistant Coroner for South Yorkshire (West)
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** On 9 November 2021 an investigation commenced into the death of Brian Parry, aged 88 years. The investigation concluded with an inquest heard on 27 July 2022. The Coroner returned a narrative conclusion
4	**CIRCUMSTANCES OF THE DEATH** Brian Parry lived at Brunswick Retirement Village, Station Road, Woodhouse, Sheffield. On 3 November 2021 he was eating in the on-site restaurant when he began to choke Back slaps were administered by staff, and he was placed on the floor in the recovery position. Assistance from additional staff was requested via the emergency cord in the restaurant Additional staff attended the restaurant. The emergency services were called by one of those members of staff, six minutes after the emergency cord was activated. CPR was administered by staff on the instruction of the emergency services On the arrival of paramedics, Brian Parry was not breathing. Paramedics removed food from his airway and began advanced life support which was unsuccessful, and he was pronounced deceased The narrative conclusion given was as follows: Brian Parry died at the Brunswick Retirement Village, Station Road, Woodhouse, Sheffield on 3 November 2021 after his airway became obstructed by food. There were missed opportunities to call emergency services between Brian Parry beginning to choke and the call being made Had emergency services attended sooner, it is likely the food would have been removed and advanced life support administered. It cannot be said whether this earlier medical attention would have prevented his death

5	**CORONER'S CONCERN** During the course of the investigation my inquiries 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 **MATTER OF CONCERN** is as follows. – I am concerned that unless staff are trained to call the emergency services immediately, further delays will occur in the administration of potentially lifesaving treatment I am concerned that when the emergency cord was pulled, the request for assistance want to care staff who were between 1 and 4 minutes away from the restaurant rather than to all staff, some of whom were near by I am concerned that despite all staff having basic first aid training, evidence was given at the inquest that not all staff are confident using their training I am concerned that there is not an advanced first aider on site available to be called upon in an emergency It is my opinion there is a risk that future deaths may occur if these concerns are not addressed
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe you 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 22 September 2022. I may extend this period upon your application 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: • The family of Brian Parry 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	**28th July 2022**  Mrs Tanyka Rawden **HM Assistant Coroner**