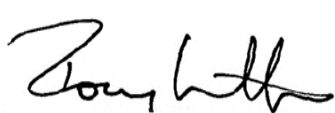


ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>1. The Right Honourable Steve Barclay MP, Secretary of State for Health and Social Care</p>
1	<p>CORONER</p> <p>I am Tony Williams, senior coroner, retired, for the coroner area of Somerset</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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 18th July 2019 I commenced an investigation into the death of Helen Ruth BURNELL, 60 years. The investigation concluded at the end of the inquest on 23rd March 2022. The conclusion of the inquest was; On 13th July 2019 at Blackdown House, Somerset Court, Harp Road, Brent Knoll Helen Burnell, who was diagnosed with Autism, was served a sandwich for dinner which had been cut in half and which was not cut up in accordance with professional advice given that only food that had been cut up in to bite sized pieces approximately 1.5 cms by 1.5 cms should be offered. Helen Burnell, under supervision at the time of eating her dinner, choked on the sandwich and suffered a fatal hypoxic brain injury. Helen Burnell had at the time of her death undergone a number of changes to her haloperidol prescription against a backdrop of having an unusual form of hypersensitivity to haloperidol withdrawal.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Choked whilst eating her dinner followed by respiratory then cardiac arrest. Approximately 1 hour 20 minutes downtime before return of spontaneous circulation. Intubated in resus and transferred to intensive care unit. Started on antibiotics to cover aspiration pneumonia. Failed to demonstrate any neurological improvement over the following days and an EEG showed no seizure activity but diffuse brain injury. Was referred for organ donation with consent of family for liver and tissues but recipient could not be found in time. Ms Burnell died 16th July 2019 at 07:09.</p>
5	<p>CORONER'S CONCERNS</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 could 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>1) I identified that better training should be given to staff in respect of choking risks.</p>

	<p>Choking is a serious health and safety risk and concern for adults with autism and those with learning disabilities. The risk of choking does not appear to have been adequately recognised by staff.</p> <p>(2) Improved training of staff, care givers and their respective managers may have the potential to increase adherence to meal time recommendations and lessen the risk of choking.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you as Secretary of State for Health and Social Care 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 7th October 2022. I, the coroner, may extend the period.</p> <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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [REDACTED], National Autistic Society, NHS Somerset Clinical Commissioning Group, Somerset Safeguarding Adults Board and the CQC.</p> <p>I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it.</p> <p>I may also send a copy of your response to any other person who I believe may find it useful or of interest.</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.</p> <p>You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response.</p>
9	<p>[DATE] 12th August 2022 [SIGNED BY CORONER]</p> <p style="text-align: center;"></p>