	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO** The Chief Executive Gloucestershire Health & Care NHS Foundation Trust
1	**CORONER** I am Roland Wooderson Area Coroner for the coroner area of Gloucestershire
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 10 October 2022 I commenced an investigation into the death of Severine Alexia Kelly born on 30 July 1981. The investigation concluded at the end of the inquest on 21 February 2024. The conclusion of the inquest held with jury was that Severine died on 1 October 2022 at Wotton Lawn Hospital Gloucester of food inhalation.
4	**CIRCUMSTANCES OF THE DEATH** Severine was detained at the time of her death under s.3 Mental Health Act 1983 and accommodated at Greyfriars Psychiatric Care Unit Wotton Lawn Hospital Gloucester. On 1 October 2022, she was provided with a sandwich by a member of the hospital staff. She choked on the sandwich. Various medical professionals attempted to assist, including nurses, paramedics and a doctor, but she died at the hospital.
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 medical training of certain "bank" staff, at the hospital on 1 October 2022, was not up to date. Staff needed to be aware of the need to update risk assessments and take appropriate action following a medical event that could be injurious to a patient. Specifically, Severine suffered a similar choking incident in 2021. A doctor, attempting to assist Severine and speak to the 999-emergency service was obliged to leave the patient to use a mobile phone. He did not have the facility of a portable landline telephone which would have meant that he could have spoken to the service without leaving the patient. A paramedic attending Wotton Lawn hospital was unsure which ward he should attend due to lack of guidance from staff at the hospital. This led to a delay in the paramedic attending on Severine. There seemed to be uncertainty at which stage of a medical emergency a medical professional should call the ambulance service. An AED used on the 1 October 2022 appeared not to have a working internal clock.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 18 April 2024. 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 – the family of Severine Kelly. 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	**Area Coroner Roland Wooderson** **21 February 2024**