Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 [redacted], CEO** **Care Outlook Ltd** **2-10 Laurel Grove** **Syndenham** **SE26 4JY** **2 [redacted]** **Manager** **Abbotswood** **Station Road** **Rustington** **Littlehampton** **BN163BJ**
1	**CORONER** I am Penelope SCHOFIELD, Senior Coroner for the coroner area of West Sussex, Brighton and Hove
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 29 December 2023 I commenced an investigation into the death of Alan Richard LEE aged 76. The investigation concluded at the end of the inquest on 04 June 2024. The conclusion of the inquest was that: On 17th December 2023 Mr Lee, who had recently been given his dinner in his flat [redacted] Abbotswood, Station Road, Rustington, Littlehampton, West Sussex, choked on a food bolus. The staff who came to his aid did not realise he had chocked and sadly he died before the ambulance arrived.
4	**CIRCUMSTANCES OF THE DEATH** On 17th December 2023 Mr Lee, who had recently been given his dinner in his flat [redacted] Abbotswood, Station Road, Rustington, Littlehampton, West Sussex, choked on a food bolus. The staff who came to his aid did not realise he had chocked and sadly he died before the ambulance arrived.

5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) The issue of concern is that despite the fact that Mr Lee had recently been given his dinner and there was evidence that some or part of it had been consumed, the staff who attended, following Mr Lee using his alarm, did not appear to consider that he may have been choking. Therefore, no life saving techniques were attempted.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) 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 August 01, 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 ██████ **(daughter)** ██████ **(Ex wife)** 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. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	**Dated: 07/06/2024** **Penelope SCHOFIELD** **Senior Coroner for** **West Sussex, Brighton and Hove**

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