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:** The Medicine and Healthcare Products and Regulatory Agency The Department for Health and Social Care
1	**CORONER** I am Miss I THISTLETHWAITE, His Majesty's Assistant Coroner for the coroner area of Rutland and North Leicestershire.
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 05 March 2024 I commenced an investigation into the death of Susan Marion LAKIN aged 72. The investigation concluded at the end of the inquest on . The conclusion of the inquest was that: Accidental death The cause of death was established as: I a Respiratory compromise by Support Belt I b Postural Impairment I c Corticobasal Syndrome and Atypical Parkinson's Disease II
4	**CIRCUMSTANCES OF THE DEATH** Mrs Lakin was a 72 year old female who lived alone with the support of her family and carers. Mrs Lakin experienced a progressive decline of her mobility and started to fall out of her armchair, her family purchased an "armchair lap belt" to prevent the falls. On 19 February 2023 Mrs Lakin slid down her armchair and under the lap belt, it became caught around her neck and she died as a result.
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: **Pre-amble** Mrs Lakin was a 72 year old female who was diagnosed with Corticobasal Syndrome which caused a progressive decline in both her mobility and memory. In 2023 Mrs Lakin started to have carers to support her at home. Her mobility continued to deteriorate and she started to use a wheelchair, she also started to fall out of bed at night and fall out of her armchair. Concerned about Mrs Lakin falling out of her armchair her family went onto the internet and found for sale an "armchair belt" which they purchased on 8 December 2023 and fitted to Mrs Lakin's armchair on 9 December 2023. The belt was used without issue until Mrs Lakin died on 19 February 2024. CCTV cameras captured Mrs Lakin slipping down her armchair and underneath the lap belt which then becomes caught around her neck. Mrs Lakin was unable to self-rescue by mobilising in the way that some people might be able to and therefore remained trapped, and effectively suspended by the lap belt around her neck, until she was found by a family member who visited her. Mrs Lakin died shortly after she was found. A post mortem report has confirmed the cause of Mrs Lakin's death to be 1a) Respiratory compromise by support belt, 1b) Postural impairment, 1c) Corticobasal syndrome and atypical Parkinson's disease. **Concerns** Mrs Lakin's family purchased the lap belt with good intentions, they wanted to keep Mrs Lakin safe. The advertisement and sales particulars for the lap belt that they purchased states *"fits any armchair*", that it provides "*extra support to prevent accidents*" and finally that it provides "*adequate trunk stability avoiding lateral displacements and slides*" and "*minimises the chance that the patient will… suffer any injuries, tilting or slipping*". The advertisement and sales particulars contain no warning about the risks that are associated with the use of the lap belt, nor any suggestion that the lap belt should be used or fitted under the guidance/supervision of a therapist or medical professional. The evidence heard at the inquest was that the lap belt should be considered a "high risk" piece of equipment (it is categorised as such in the local NHS Trust's Standard Operating Procedure) and that appropriate warnings should be given to those purchasing lap belts in relation to the risks of physical restraint, tissue viability risks and finally the risk of strangulation. It is concerning that people who have no healthcare training at all can purchase high risk equipment for their loved ones online without being appraised of those risks or even being informed about the high risk nature of the equipment. Lap belts, and other seemingly basic pieces of healthcare equipment, are readily available for people to purchase online without them being appraised of the risks that come with the use of the same.
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 May 30, 2025. 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 Mrs Lakin's family The Leicestershire Partnership NHS Trust Care at Home (Midlands) Limited The Care Quality Commission I have also sent it to Amazon UK who may find it useful or of interest. 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: 11/04/2025**  **Miss I THISTLETHWAITE** **His Majesty's Assistant Coroner for Rutland and North Leicestershire**