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 The Secretary of State for the Department of Environment Food and Rural Affairs (DEFRA)** **2 The Royal Society for the Prevention of Accidents**
1	**CORONER** I am Michael James Pemberton, HM Area Coroner for the coroner area of Manchester (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 and INQUEST** On 29 April 2025 I commenced an investigation into the death of David Joseph HAYES aged 82. The investigation concluded at the end of the inquest on 17 July 2025. The conclusion of the inquest was Accident, and the medical cause of death was 1a Pneumonitis 1b Aspiration due to ingestion of a chemical substance.
4	**CIRCUMSTANCES OF THE DEATH** The deceased suffered from Dementia in Alzheimer's disease and was admitted to the Royal Bolton Hospital on 16 April 2025 following a previous attendance and discharge due to accidental ingestion of a washing detergent on 15 April 2025. This had occurred when he had made a cup of tea at home and put washing detergent into the cup instead of milk after an apparent confusion. He had vomited following the ingestion and it is likely that he aspirated. On admission, he was discovered to be suffering from suspected pneumonitis which was considered likely to have arisen from aspiration of detergent and stomach acid when vomiting after the accidental ingestion. He received treatment by antibiotics, steroids and analgesia. He experienced atrial fibrillation, and his heart rate remained inadequately controlled despite treatment. He continued to decline, and palliative care was provided. He passed away on 21 April 2025.
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: 1. During the course of evidence it was noted that the plastic bottle like packaging in which the white liquid washing detergent was contained was confused by the deceased as a milk carton. He suffered from dementia and appeared to have poured the liquid into a cup of tea he had made, subsequently placing the detergent container in the fridge.

	2. The container had a screw top with no safety features meaning that it would be easily accessible by a person with reduced capacity or dementia, or even a child enabling the contents able to be consumed with apparent ease. 3. Whilst the liquid was deemed to have low toxicity, on the evidence it led to vomiting and aspiration causing damage to the lungs and subsequent breathing difficulties. In this case this was causative of death. 4. In my judgment, there is a risk of similar events in respect of the ingestion of a liquid washing detergent because: a. The colouring of the liquid is similar to items which a person suffering from an infirmity such as dementia may get confused – here milk b. The shape of the packaging could be misconstrued in these circumstances c. The screw top lid with no child or resistance protection is easily accessible. 5. The level of printed warnings on the labelling was not explored during the hearing, but this may not specify that the item could be a risk to vulnerable adults as well as the need to keep out of the reach of children. 6. The public knowledge of these risks is not likely to be at a level where households in which vulnerable adults reside are aware of the need to safeguard detergents and make them less accessible.
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 12 September 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 [redacted] I have also sent it to **Age UK** **Dementia UK** **Alzheimer's Society** 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: 18 July 2025**  **Michael James Pemberton** **HM Area Coroner for Manchester West**