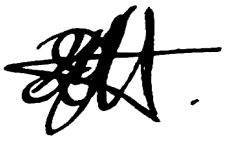
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Beccles Medical Centre, Beccles, Suffolk**
1	**CORONER** I am Darren STEWART OBE, HM Area Coroner for the coroner area of Suffolk
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 12 December 2023 I commenced an investigation into the death of Kathleen Mary GREGORY aged 74. The investigation concluded at the end of the inquest on 20 November 2024. The conclusion of the inquest was that: Accident The medical cause of death was confirmed as: 1a Asphyxia 1b Food in Airway
4	**CIRCUMSTANCES OF THE DEATH** On the 29th November 2023 at around 13:30 hours, Kathleen Mary GREGORY was found collapsed in bed by staff at her care home. She appeared to be choking on food which had earlier been left for her by staff for lunch. Staff sat Mrs. Gregory upright and checked to see if there were any obstructions in her upper airway. None could be observed. A paramedic who had been attending the care home was called to assist. Upon his arrival Mrs. Gregory had no pulse and did not appear to be breathing and he verified her death at 13:45 hours. A subsequent Post-mortem examination confirmed that Mrs. Gregory had died due to asphyxia caused by food which had become lodged at the larynx in her airway. Police enquiries revealed no suspicious circumstances or third party involvement in the death.
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) **During the course of the Inquest the Court heard evidence that the paramedic employed by Beccles Medical Centre who attended Mrs. GREGORY on the 29th**

	November 2023 interpreted a Recommended Summary Care Plan for Emergency Care and Treatment (ReSPECT) in place at the time as meaning that resuscitation attempts should not be attempted in circumstances where an un-natural event such as choking was taking place. **I am concerned that such an approach does not appear to be consistent with the terms of a ReSPECT Form and its application in circumstances of an event such as choking where an adverse outcome may be reversable.**
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 14th, 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: **Family of Kathleen Mary GREGORY** **Beccles Care Home** I have also sent it to: **The Care Quality Commission** who may find it useful or of interest. 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	**Dated: 18/06/2025**  **Darren STEWART OBE** **HM Area Coroner for** **Suffolk**