REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Food Standards Agency –** [redacted] **Health and Safety Executive –** [redacted] **East Riding Council –** [redacted]
1	**CORONER** Miss Lorraine Harris, Area Coroner, East Riding of Yorkshire and City of Kingston Upon Hull.
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 13th June 2025 I commenced an investigation into the death of Stuart GILCHRIST, aged 77 years. The investigation concluded at the end of the inquest on 8th September 2025. The conclusion of the inquest was: *ACCIDENT* The following findings of fact were made: • *Mr GILCHRIST had a history of suffering with his mental health, and was therefore in a supported living care facility under DOLS.* • *His past medical history included schizophrenia and Type 2 Diabetes Mellitus. These were originally included in his cause of death under section 2 but given the circumstances and mode of death they did not contribute to his demise and as such I do not feel they belong on the cause of death but rather in my Findings of Fact.* • *Mr GILCHRIST had been very ill in Autumn of 2024 and been on a restricted diet, I find this was necessary and appropriate at that time.* ○ *When on a pureed diet, Mr Gilchrist did not like the presentation of his food, but he did eat it.* • *Mr GILCHRIST was discharged from the Speech and Language Therapy Service (SALT) – the team that gave advice re diet - in January 2025 following observations in December 2024. This again was appropriate.* • *In May 2025 Mr GILCHRIST choked on a bacon sandwich. The Care Home sought medical attention which advised observations and issued*

	antibiotics with regard to any residual chest infection. The Care Home did the right thing by referring for medical attention. o *Had they referred the matter to SALT then a telephone assessment would have taken place. In the circumstances and with hindsight, this would have been best practice. However, given that a telephone consultation would have taken place and it would have been reported that, bar this incident, Mr GILCHRIST had been coping on a normal diet, I find that it would not have made a difference to Mr GILCHRIST's diet at the time of his death.* • *On the day of his death, Mr GILCHRIST was on a trip out with care home staff and other service users. The staff to service user ratio was appropriate. It is worthy of note that Mr GILCHRIST was in an area that was very dear to him.* • *When Mr GILCHRIST's food arrived, it was cut up appropriately and he was in sight of staff during the meal.* • *As soon as Mr GILCHRIST's demeanour changed it was spotted in a timely manner by care home staff. Immediate and appropriate first aid was given by way of back slaps following by abdominal thrusts, both of which were unsuccessful. Emergency services were called immediately and staff conducted cardio-pulmonary resuscitation (CPR).* • *Staff called for a "LifeVac" suction device which is available in many care homes but not necessarily available in restaurants, one was not available.* • *Paramedics arrived and used forceps and a laryngoscope to remove a large amount of potato and meat from Mr GILCHRIST's airway. CPR continued and he was conveyed to hospital.* • *RPFD – I will make a report to those who have oversight for safety in Restaurants regarding the usefulness of LifeVac type facilities.* Box 3 of the record of inquest read: *On 11th June 2025 Stuart GILCHRIST, aged 77 years, attended a restaurant for lunch with staff and other service users from his care home. During the meal Mr GILCHRIST stood up from the table and it was evident that he was unable to breath. Despite prompt assistance from staff with back slaps and abdominal thrusts, Mr GILCHRIST collapsed and cardiopulmonary resuscitation (CPR) was immediately commenced. An ambulance attended and removed food from his airway, they continued with CPR but on arrival at Hull Royal Infirmary Mr GILCHRIST was in cardiac arrest. CPR was continued but unsuccessful and Mr GILCHRIST was declared deceased that day.* His medical cause of death was recorded as: ***1a*** *Hypoxic Brain Injury* ***1b*** *Choking*
4	**CIRCUMSTANCES OF THE DEATH**

	In June 2025 Stuart GILCHRIST was out with carers and other service users from his care home when he choked while eating lunch at a restaurant. He had previously been on a restricted diet due to swallow issues following ill health in Autum 2024 but since December 2024 been deemed suitable for a normal diet and discharged from the SALT team in January 2025. He did have one further episode of coughing/choking on food in May 2025. Medical assistance was sought, SALT were not contacted for a re-referral. Care staff did all they could to assist Mr GILCHRIST with back slaps, abdominal thrusts and eventually CPR. During this assistance the Care Staff member asked if the restaurant had a LifeVac style device, which is an inexpensive item that can help remove items from someone's airways. This device is available at the Care Home. The restaurant did not have one.
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. – 1. During the evidence it was heard that there is a device that may assist in incidents of choking, it was referred to as a LifeVac (this may be a trade name). The care staff member, had recognised that Mr GILCHRIST was choking and while administering assistance to him had the foresight to ask if the restaurant had a "LifeVac" style device. 2. It was acknowledged during the inquest that restaurants have first aid items and some may have equipment such as a defibrillator however they may not be aware that this useful item exists, nor that it is relatively inexpensive. 3. At the time the evidence was heard, I was unaware of who would be responsible for advising restaurants and food establishments of the availability of such an item, or to raise with those outlets its usefulness should a customer begin to choke; so therefore this RPFD is sent to three organisations who may have varying levels of responsibility - without restaurants and food establishments being made aware of such an item, they may not think to purchase one and retain it within their first aid armoury. 4. I also appreciate that LifeVac is probably a trade name and I only use it to describe the type of item that would be deemed useful.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your department/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 5th November 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 family of Mr Stuart GILCHRIST • The Care Home where Mr GILCHRIST was a resident • The Food Standards Agency • The Health and Safety Executive • Heath and Safety at East Riding of Yorkshire Council 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 other 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. She 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.
9	**[DATE]** **[SIGNED BY CORONER]** ***10th September 2025*** ***Lorraine Harris***