	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Curo Care Delaheys Ltd.** **C/O Delaheys Nursing Care Home** **215 Clifton Drive South,** **Lytham St Annes** **FY8 1ES** **Care Quality Commission** [redacted]
1	**CORONER** I am Alan Anthony Wilson Senior Coroner for **Blackpool & Fylde**
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUES** The death of Bonita Cleary on 11th October 2025 at Delaheys Nursing Care Home, Lytham St. Annes was reported to me and I opened an investigation which concluded by way of an inquest on 8th January 2026. I determined that the medical cause of death was: **1a Choking** 1b 1c 1d II **Severe frailty, left ventricular hypertrophy, coronary heart disease, dementia.** In box 3 of the Record of Inquest I recorded as follows:

	Bonita Cleary was aged 75 years. Her medical history included dementia and she was known to be severely frail. She was not regarded as being at risk of choking, but sufficiently frail that when eating, her food needed to be easy to chew and a member of staff present. On 11th October 2025, at a time when a Care Assistant had commenced feeding her small portions of crumpet for lunch, Bonita started coughing and had what has been described as a vacant episode. Her jaw became clenched. She began choking and the food caused an obstruction of her airway. She had a DNACPR [Do Not Attempt Cardio – Pulmonary Resuscitation] authorisation in place. CPR was not initially commenced with a view to trying to reverse the effects of choking until a Paramedic attended who was able to remove food from Bonita's airway but by that stage from the available evidence she could not be revived. A subsequent post – mortem examination confirmed she died from the effects of choking, her death more than minimally contributed to by her known severe frailty, compromised heart function, and dementia. In box 4 of the Record of Inquest I determined that: **Misadventure**
4	**<u>CIRCUMSTANCES OF THE DEATH</u>** In addition to the contents of section 3 above, the following is of note: • Bonita Cleary was largely bedbound during her final weeks; • She was not regarded as at significant risk of choking, and she was not restricted in terms of the range of foods she could eat, but there was a need to for a member of staff to be with her when she ate; • With a member of staff in attendance, she began eating some pieces of crumpet which had been cut up for her; • She did have a history of what were described as seizures / vacant episodes of varying duration, and on such occasions her jaw could become clenched and lock; • This happened unexpectedly after she began eating the crumpet, and she appeared to be choking. A member of care staff, and then a nurse, both of whom were familiar with Bonita and had cared for her for many months, tried to assist her by making attempts to clear any food from her mouth; • When a paramedic attended, CPR was not being performed; • The Paramedic made efforts to remove more food from the airway, and commenced CPR, but in due course it was confirmed Bonita had died; • There was a DNACPR (Do Not Attempt Cardio-pulmonary resuscitation) authorisation in place;

	• It seems there was a lack of awareness that even if there is a DNACPR in place, CPR can be commenced to respond to potentially reversible causes. Choking is one such reversible cause; • The Nurse gave helpful evidence at the inquest, whilst acknowledging that despite her years of experience, and had previously received basic life support training, she was not fully aware that CPR may still be required in the event of a potentially reversible cause and she firmly expressed the view there is a lack of guidance on this issues for medical professionals and care workers employed in a care setting. A senior manager in attendance at the inquest agreed. • I considered if, had effective CPR been commenced immediately, this would have made a difference to the outcome for Bonita? Although I could not rule this out, I regarded it as unlikely. Having considered all of the above, I have determined that I have a duty to write this report.
5	**<u>CORONER'S CONCERNS</u>** 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 send the report: The **MATTER OF CONCERN** is as follows. – • Bonita Cleary died due to a choking episode. • This is a potentially reversible cause. • Notwithstanding there was a DNACPR authorization in place, CPR ought to have been commenced • On balance of probabilities, this would not have saved Bonita's life, but for other vulnerable residents in a care setting, effective and timely CPR may prevent death; • I am concerned that there is a lack of awareness amongst care and nursing staff within this organization and the care sector more widely about when CPR should be attempted, and that residents with a realistic chance of surviving may die as a result of a cause which was, in fact, potentially reversible. • It is not for me to be prescriptive about what can / should be done, but there is a clear risk and therefore I raise this concern.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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, and therefore by 5th April 2026. I, the Coroner, may extend the period further. 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: • The family of Bonita Cleary 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. She may send a copy of this report to any person who she 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	07/02/26 Signature_____ Alan Anthony Wilson Senior Coroner **Blackpool & Fylde**