ANNEX A

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:** **1. Moundsley Hall Nursing Home** **2.** **3.**
1	**CORONER** I am Geraint Urias Williams, Senior Coroner, for the coroner area of Worcestershire
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 2nd October 2013 I commenced an investigation into the death of Henry MCQUOID then aged 89 years. The investigation concluded at the end of the inquest on 29th October 2013. The conclusion of the inquest was "accidental death" the medical cause of death being 1(a) choking on food .
4	**CIRCUMSTANCES OF THE DEATH** Mr McQuoid was a resident at Moundsley Hall Home and suffered from dementia and swallowing difficulties. Whilst eating his lunch at the home he choked on food and died. The evidence given was that whilst there were a number of staff available to help Mr McQuoid and others who needed help with feeding there may have been an insufficient number of staff available to deal with the number of residences who needed help.
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 will 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) Evidence given by the family suggested that there were an insufficient number of staff to provide assistance with eating for each resident who required it and that the family had been told by some members of staff that they themselves felt under staffed with too many agency staff being employed and thus a possibility that some residents who needed help in feeding might not receive it. (2) (3)
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 - specifically to review staffing levels at the home.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 31st December 2013 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 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	**Signed** **G U Williams** **H M Senior Coroner** **6th day of November 2013**