**ANNEX A**

**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)**

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

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1. Philips Respironics**<br>**2. British Oxygen** |
| 1 | **CORONER**<br><br>I am Clare Bailey, acting senior coroner, for the coroner area of Teesside. |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 3 December 2014, I commenced an investigation into the death of Sandra Danks age 71. The investigation concluded at the end of the inquest on 3 December 2014. The conclusion of the inquest was that Mrs Danks died of an accident. The medical cause of her death has been recorded as Anoxia due to Oxygen Pump Failure. Her death was also contributed to by Ischaemic and Hypertensive Heart Disease and Fatty Liver. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Mrs Danks required 24 hour oxygen at home due to her medical conditions. The oxygen was fed through tubing directly from an 'Everflo API' by Respironics. The machine was situated on the upstairs landing of the property. Various tubes were connected to a junction switch which could be used to whatever setting was required, allowing Mrs Danks to have access to oxygen supply. At about 8.30am Mrs Danks' son telephoned [redacted] who was away from home, to say the electricity supply had gone off [redacted] rushed home to assist his wife. She had been unable to utilise the spare oxygen bottle nearby once the electricity shortage had switched off her main oxygen apparatus. She passed away as a result. At the Inquest [redacted] informed me that there had been a similar incident in September 2014. Fortunately, he was able to return home in time to access the spare oxygen bottle and provide his wife with oxygen. |
| 5 | **<u>CORONER'S CONCERNS</u>**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>(1) An interruption in the electricity supply to the main oxygen apparatus stopped the oxygen provision and there was no back up on the main oxygen apparatus to continue to provide oxygen, thus leaving Mrs Danks in a very vulnerable position. |

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| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 28 January 2015. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely [redacted]<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **DATE** **SIGNED BY CORONER** |