[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Church Inn 90 Ravenoak Rd Cheadle Hulme**
1	**CORONER** I am Christopher Murray Assistant Coroner for **Manchester South**
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 INQUEST** On 13/02/2017 I commenced an investigation into the death of William Joseph WILSON. The investigation concluded at the end of the inquest 8th June 2017. The conclusion of the inquest was Mr Wilson was enjoying a meal at the Church Inn, [redacted] on the 26th November 2016 when he suddenly choked as a result of a piece of steak becoming lodged in his throat. He was asphyxiated and suffered a fatal hypoxic brain injury and died at The Meadows, Stepping Hill Hospital on the 2nd February 2017. Hypoxic Brain Damage Choking Hypertension
4	**CIRCUMSTANCES OF THE DEATH** Date Admitted: 26/01/2017 Consultant responsible for patient at time of death: [redacted] Patient brought in by ambulance to the emergency department on the 26/1/2017 at 14:58 following a choking on a large piece of steak. Attended by paramedics within 4 minutes of choking and was resuscitated following which he expelled a large piece of steak. Unfortunately, he sustained hypoxic brain damage and was in coma as a result and following intensive care review it was considered that this was a terminal event and he was transferred to medical ward for end of life care. He was treated for aspiration pneumonia but deteriorated further with no improvement in his conscious levels. Following discussion with his daughter it was considered that palliative care would be provided in Bluebell ward where he died on the 2/2/2017. Relevant PMH Hypertension
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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) I was informed in evidence by the manager of the Church Inn that the designated first aider was the Chef who was not called to the scene. (2)The Manager of the Church Inn was unable to inform me of the system for alerting the first aider to

	any problem to ensure he attended the scene. (3)The manager and his colleague who attended upon the deceased were unfamiliar with all of the first aid life saving techniques when dealing with Mr Wilson.

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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, namely by 11th August 2017. 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] daughter of the deceased. 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	12/06/2017 Signature_____ Christopher Murray Assistant Coroner **Manchester South**