Regulation 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** Association of Ambulance Chief Executives Nursing and Midwifery Council
1	**CORONER** I am Alan Romilly CRAZE, HM Senior Coroner for the coroner area of East Sussex
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 14 June 2021 I commenced an investigation into the death of Robert George MURRAY aged 80. The investigation concluded at the end of the inquest on 16 March 2022. The conclusion of the inquest was: accidental death
4	**CIRCUMSTANCES OF THE DEATH** The deceased suffered from mild dementia and was cared for in a nursing home. At breakfast on 10 June 2021 he choked and died. Autopsy found a food bolus in his airways. An ambulance, wrongly, was not sent because he had a DNACPR in place.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: From listening to the 999 call between the registered nurse at the care home and the call operator, and also from evidence heard at the inquest, it is apparent that no one involved understood that there are circumstances when the DNACPR should not be applied. I am concerned that this may potentially be an issue elsewhere in the country and further training and clarification is therefore necessary.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your 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 19 May 2022. 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: Family of Mr Murray South East Coast Ambulance Service NHS Foundation Trust Avalon Nursing Home, Eastbourne I have also sent it to: Resuscitation Council UK Care Quality Commission NHS England East Sussex Healthcare NHS Trust who may find it useful or of interest. 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 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. 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	**Dated: 23/03/2022**  **Alan Romilly CRAZE** **HM Senior Coroner for** **East Sussex**