MISS N PERSAUD
HIS MAJESTY'S CORONER
EAST LONDON
Coroner's Court, 124 Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Ref: [redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Group Operations Director, Abbey Healthcare, Sutherland House, 70-78 West Hendon Broadway, London, NW9 7BT Sent via email: [redacted]
1	**CORONER** I am Nadia Persaud, Area Coroner for the coroner area of East London
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 20 February 2024 I commenced an investigation into the death of Elan Gransford Adams (aged 69 years old). The investigation concluded at the end of the inquest on the 18 November 2024. The conclusion was that Mr Adams died as a result of an accident (choking on food in care home setting).
4	**CIRCUMSTANCES OF THE DEATH**

	Mr. Adams resided in a nursing home. He was not at known risk of choking and there was no evidence of dysphagia. He was able to eat a level seven (normal), diet. He required staff to provide meals to him. On the 5 February 2024, Mr. Adams was provided with a burger at around 630pm. When staff attended to collect his plate, at around 7pm, he was found with the burger scattered over his lap and he was not fully responsive. The care assistant called for a nearby nurse. The nurse attended and a set of observations were taken, which were concerning and included an oxygen saturation of 87%. At 7.14pm a call was made to the London Ambulance Service. A poor history was provided by the nurse; the call sound quality was poor and there was a lack of clarity around Mr. Adams' respiratory status. During the call, Mr. Adams stopped breathing and the staff carried out chest compressions under the guidance of the LAS call handler. Paramedics arrived at 7.41pm and took over resuscitation efforts. On inspection of the lower airway, utilising specialist equipment, a food obstruction was seen, and attempts were made to clear this. After removing the visual obstruction, ventilations became effective, and a return of spontaneous circulation was achieved. Mr. Adams was taken to Newham University Hospital. Emergency care continued, but sadly there was no further response. Mr. Adams passed away at Newham University Hospital at 853pm on 5 February 2024. A post-mortem examination confirmed the cause of death to be choking on a food bolus.
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 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: (1) The call to the London Ambulance Service was of very poor quality partly due to interference in the phone line connection. The inquest heard that the staff had problems with the phone quality "most of the time" and continue to have difficulties when making emergency calls from resident's bedrooms. (2) The qualified nursing staff were concerningly unclear in the substance of communication with the emergency controller. They were unable to clearly answer the question about breathing status. They did not provide key clinical information to the controller, such as the much-reduced oxygen saturation reading. (3) The resident call bell had been faulty for an extended period of time. Whilst a handheld bell was provided, there was little assurance that staff could hear this during busy periods, such as during mealtimes. The family had been present on a prior occasion when the temporary bell had been rung and no staff attended.
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 23 January 2024. 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, to the family of Mr Adams, to the London Ambulance Service, the Care Quality Commission, and the local Director of Public Health 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 other 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.
9	**26 November 2024**