

**REPORT BY JEMMA CIEROCKI**  
**TO HM CORONER**  
**IN RESPECT OF THE INQUEST OF PHILLIP LESLIE JONES**

In the first instance, please extend our condolences to Mr Jones' loved ones, we understand this would have been incredibly distressing for them.

Mr Jones was living with a diagnosis of dementia prior to his passing. CQC expects registered providers to ensure care and support is delivered in a way that manages risk, whilst balancing this with a person's independence. After an assessment of his needs, Mr Jones continued to manage his oral healthcare independently. Fixodent was stored in Mr Jones' bathroom for him to use and there were no previous known occasions when Mr Jones had ingested this. As I am sure you are aware, CQC has specific criminal enforcement powers when avoidable harm has occurred, or when a service user has been exposed to a significant risk of such harm occurring. Due to the circumstances of Mr Jones' passing, we reviewed the incident in line with our specific incident guidance. This was to establish whether there were failings in care that could have been attributed to a registered person/provider failure. In summary, we found Mr Jones' death was not the result of avoidable harm resulting from a registered person/provider failure.


The provider has investigated the circumstances of Mr Jones' passing. In summary, the findings conclude that, while there was no specific risk assessment regarding the management of Fixodent, Mr Jones had been safely managing his oral health care, and Fixodent use, since his admission to the service in 2022. As part of the aforementioned investigation, the provider had reviewed lessons learned. Actions planned by the provider included the organisational sharing of information about the circumstances of Mr Jones's passing, to raise awareness. Additionally, identifying residents who use denture adhesive products, or similar, with a view to reviewing documentation and safety measures. Although we believe these adhesive gels are not considered medical devices and are thus not under MHRA's remit, they may be able to assist with further communications to raise awareness of the risk with the product manufacturers.

I note you have requested the Chief Executive Officer (CEO) of Fixodent should consider placing a warning on packaging so it is clear that ingestion of the product is a potential risk. It is important to consider brands beyond just Fixodent (the CEO of which is listed as the other named respondent in the Regulation 28 report). There are several brands of denture adhesive gel available which will potentially carry the same choking risk due to the substance consistency. The patient safety leaflets of two popular brands of denture adhesive were reviewed and neither contained choking as a hazard, though they do advise what to do in the event of ingesting or inhaling. It is not within the CQC's remit to raise this issue with the CEOs of these companies, so further action may be required by HM Coroner and/or the Office for Product Safety and Standards.

In terms of action that will be taken by CQC, it is recommended that this incident should be featured as an issue on CQC's [Learning from safety incidents](#) webpage. This would help raise awareness and share the learning with providers to help prevent similar incidents in the future. This webpage should reference:

Risks relating to denture adhesive gel (as a product generically – there are multiple brands on the market)

- Advise providers to consider denture adhesive gel in the following risk assessments:
- Health and Safety Executive's [COSHH Risk Assessment](#), in accordance with the Control of Substances Hazardous to Health Regulations 2002.
- Risk assessments carried out relating to the health, safety and welfare of people using services, in accordance with [Regulation 12: Safe care and treatment - Care Quality Commission](#). Individualised risk assessment and care planning that should already be taking place should ensure vulnerable people are identified and protected.
- Remind providers of the existing expectation that they should undertake a [risk assessment for oral health](#) in line with [NICE guidance](#).
- Advise providers to consider in care planning:
- There are also different types of denture adhesives – strips, powder and creams – which can be used to secure dentures and should be considered on a case-by-case basis.
- Existing guidance relating to dementia and oral health, such as is featured on this webpage [dementia UK](#).

  
Operations Manager