

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: <ol style="list-style-type: none">1. CEO of Fixodent2. Care Quality Commission
1	CORONER I am Richard T Middleton, Assistant Coroner, for the Coroner Area of Dorset
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 the 5 th July 2024, an investigation was commenced into the death of Philip Leslie Jones, born on the 15 th September 1931. The investigation concluded at the end of the Inquest on the 20 th February 2025. The Medical Cause of Death was: <ol style="list-style-type: none">1 (a) Hypoxic brain injury (b) Choking (c) Inhalation of adhesive gel2. Dementia The conclusion of the Inquest recorded Accident
4	CIRCUMSTANCES OF THE DEATH In August 2022 Mr Jones was diagnosed with dementia and on 6/9/22 he took up residence at a care home which specialised in such care. On 23/6/24 a member of staff found Mr Jones in his room with denture adhesive gel in his mouth, ears and nose. Attempts were made to remove the substance from his mouth. Mr Jones' breathing became laboured and paramedics attended and took him to hospital where his health deteriorated and he died on 23/6/24.

CORONER'S CONCERNS

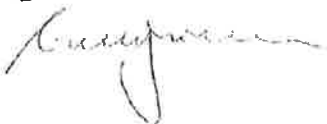
The **MATTERS OF CONCERN** are as follows:

1. During the inquest evidence was heard that:

- i. Mr Jones lived in a self-contained unit at the care home where he had his own room and en suite facilities.
- ii. Upon his arrival risk assessments were carried out including choking hazards and a full Care Plan created which included oral care.
- iii. Although Mr Jones was living with dementia, he was able to care for himself except for being prompted and with the support from one care staff with his personal care.
- iv. He had capacity to make daily non-complex decisions. He wished to maintain his independence as far as possible with all aspects of his daily care needs. He was able to manage elements of his own daily personal care which included oral care.
- v. Mr Jones had upper and lower dentures which he secured in place on a daily basis using an adhesive gel. He had daily access to this gel which was stored in his bathroom cabinet. There were no reported concerns regarding his daily access to the adhesive gel. The gel and other toiletries were provided by his family.
- vi. When paramedics attended on 23/6/24 they attempted to remove the gel with a suction machine but were unsuccessful.
- vii. At autopsy there was evidence of upper airway obstruction by thick adhesive gel. This thick adhesive gel was seen inside the mouth and pharynx and had completely blocked the larynx and trachea and extended into the left bronchus
- viii. The packaging of the gel was examined and there was no warning on either the box or the enclosed leaflet that gave a warning that the gel was a potential choking hazard.

2. I have concerns with regard to the following:

- i. The choking risk which this product poses. The qualities of the product are such that a thick adhesive gel can become lodged deep into the respiratory system and can be extremely difficult to remove
- ii. Such a product is likely to be used by the older generation and those who may be suffering from a decline of brain functioning.

	<p>iii. Such a product should be considered as part of any risk assessment for those living in a care home setting.</p> <p>iv. There is no warning on the product packaging or on the enclosed information leaflet as to the risk of choking.</p>	
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion urgent action should be taken to prevent future deaths and I believe you and/or your organisation have the power to take such action.</p>	
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report namely by 24th April 2025. I, the coroner, may extend the period.</p> <p>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.</p>	
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:</p> <p>(1) Mr Jones' Family (2) Southbourne Beach Care Home</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>	
9	<p>Dated</p> <p>27th February 2025</p>	<p>Signed</p>  <p>Richard T Middleton</p>