Please find below our response to the PFD Report dated 9th April 2025 Re Ivy May Dixon (DOD 06/10/2024) as sent by the Assistant Coroner Mr Ian Potter to:

The Directors

Lukka Care Homes Ltd

Macnell House

9 – 17 Lodge Lane

London

N12 8JH

	Issue to be addressed	Action to be taken by the home
	In the PDF report (Appendix One), Section 4 (Circumstances of death) it is stated: *The circumstances of Mrs Dixon's death are encapsulated with the narrative conclusion from the Inquest, which was as follows:* *'Ivy Dixon choked on food causing cardiac arrest while being fed by staff in her room at Acorn Lodge Care Home on 6th October 2024. Carers called an ambulance but did not perform CPR when Mrs Dixon became unresponsive prior to an ambulance arriving.* *Mrs Dixon had a DNACPR order in place, which would not apply to an episode of choking. This is because choking is a potentially reversible cause of cardiac arrest.*	

	Care staff told the paramedics that Mrs Dixon had not been fed that evening. This was not true. This led paramedics to conclude that Mrs Dixon's cardiac arrest did not have a reversible cause. It is unclear whether, if paramedics had been given a correct account of events, the outcome would have been any different.' The details in the entries on our electronic care planning system (Appendix One) clearly state the type and amount of food that had been given to Mrs Dixon and that when the staff checked her shortly afterwards, they found that her breathing pattern had changed. The nurses were called and back slaps and suction was given and relevant observations taken with a 999 call being made at 18.15 hrs. The staff are very clear that they told the call handler that they believed Mrs Dixon was choking and this is confirmed in the statement of [redacted] at the bottom of page 2 of her report. (Appendix Two) It can also be seen from the entry in the care notes which can be found in (Appendix One) that the paramedic taking the ECG asked the staff to inform the family that Mrs Dixon's condition was deteriorating before confirming a little time later that she had died. As far as the staff were aware at the time of the LAS arrival, Mrs Dixon was still alive and therefore would not have commenced CPR but had handed over her care to the Paramedics.	All the staff are trained and competent in assisting residents with their food and fluids in accordance with their care plans, including any directions from such as the Speech and Language Therapy (SALT) team It is clear from the differences in the statements from the LAS and the information recorded by the staff of the home that there had, for whatever reason been a miscommunication/understanding between the LAS and our staff around whether or not Mrs Dixon had swallowed any food. We do not believe it to be the case that our staff deliberately mislead the LAS

	We also attach in Appendix One, an email from Mrs Dixon's grandson that outlines that he had received two calls from the home: *'I got a call from your staff today saying that my grandmother's oxygen level was low and could I come to the care home as the ambulance was there. Within a few minutes I got another call saying that my grandmother has pass away'* This concurs with our belief that Mrs Dixon was still alive at the time the LAS attended. As always, the 999-call handler will have stayed on the line until the arrival of the LAS. We have not had the benefit of being able to listen to the call/read the transcript but wonder if this would clarify the situation	It would be useful for our staff if the home could have a transcript of the call.
	Communication – As outlined above, we feel that there appears to be have been some communication issues between the paramedics and our staff. There was no reason for the staff to say to the paramedics that Mrs Dixon had not taken any food when they had been so clear in reporting this to the 999-call handler. Our records are very clear that she had taken pureed food prior to the HCA noticing that she was breathing noisily and relevant action being taken by our staff in terms of back slaps and the use of suction. We agree that once food is removed from the immediate area in the oral pharyngeal region, it would appear that there was no food present at first glance and our concerns are that on seeing there was no food visible the LAS service took the view that choking was not the cause of Mrs Dixon's deteriorating condition.	We will use this unfortunate incident to raise learning and development opportunities for our staff however feel strongly that our staff are already confident and competent to deal with professionals from all backgrounds including paramedics in an emergency situation. We see no reason to doubt that the correct information regarding the food

	According to the provisional cause of death of Mrs Dixon, cause 1a was Aspiration and 1b was Choking so clearly food had been ingested and, as previously mentioned, this is evident in our care plan notes and the statements of our staff. Our staff are of the belief that although there was evidence of deterioration, Mrs Dixon was still alive at the time of the paramedic's arrival and that is the reason our staff had not already commenced CPR. Their entries onto our electronic care plan system, as previously mentioned, indicate that following the initial ECG carried out by the paramedics where along with their observations, the paramedics advised that Mrs Dixon's condition was deteriorating and her family should be informed. They also go on to say that at 18.31 hrs the paramedics verified death In relation to the timeline of the involvement of the LAS on the 06/10/2024, we can see from the statement of [redacted] that the call was made by the home to 999 at 18.15 hrs stating clearly that Mrs Dixon was breathing and conscious with the problem being described as 'Choking'. A crew was dispatched very quickly and arrived at the home (according to their own records) at 18.21 hrs. We can see from their records that they understood from the history provided that the care home staff were attempting to feed Mrs Dixon and that she had not actually taken any food prior to her becoming unresponsive and making gasping sounds and as the staff were concerned, they called 999.	that Mrs Dixon had been given had been shared with the paramedic team at the time of their arrival but we are using this as a point of learning for our staff to ensure that they are very clear in the information that they give under such circumstances must be accurate and to ensure that the person(s) they are giving the information to fully understands the information

	This version of events directly conflicts with the accounts given by the members of staff on duty and dealing with Mrs Dixon at the time. We can see from the Addendum Statement provided by [redacted] (Appendix Two) she has relied on her ePCR to provide her statement. Unfortunately, we have not had the opportunity to view the ePCR to compare it against our own notes. We also note that the statement we have of [redacted] is an Addendum, we have not seen the original statement and wonder why an addendum was required?	
	With regards to the training, skills and competence of our staff, our nurses undertake CPR training every 12 months and the staff on duty on that day were up to date with their training. However, given the tight time line of events, there had only been 6 minutes between the 999 call being made and the attendance of the LAS. As previously mentioned, our staff are of the belief that at the time of the arrival of LAS, Mrs Dixon was still alive but deteriorating and care was taken over by the LAS at 18.21 hrs, only 6 minutes after the 999 call being made. Had our staff found that Mrs Dixon had suffered a cardiac arrest prior to the arrival of the LAS then they would have commenced CPR immediately as they are trained to do. In the clinical notes of [redacted]s statement (Appendix Two, page 5, para 12) it states that the staff informed that no food had been provided to Mrs Dixon prior to their arrival on scene. As previously	We will continue to ensure that our nursing and care staff receive up to date training with regards to CPR and the management of emergency situations including ensuring as previously mentioned that accurate information is given to visiting professionals taking over a person's care. Following the incident with Mrs Dixon Acorn Lodge has been committed to

	stated, we do not believe this to be the case, and the post mortem report shows (as noted in Ms Hill's statement (Appendix Two, page 4) that 'the trachea-bronchial tree was obstructed by greenish/grey pureed food'. Whilst we note on page 5, that [redacted]'s statement outlines that the attending clinician undertook a visual inspection of Mrs Dixon's airway from her semi recumbent position however there was no food noted and a decision was made that it was unlikely that Mrs Dixon was choking and therefore no further action was taken by LAS and Mrs Dixon was verified dead at 18.31 hrs. We are not sure why the paramedic believed that Mrs Dixon had not taken any food, or, did not understand that although the nurses had used back slaps and suction to remove any food they could, there may still be food present lower down causing an obstruction and therefore CPR should have been attempted. In para 20 of [redacted]'s report, page 7 (Appendix Two), [redacted] outlines that: *'20. On review of the information provided, and in consideration of Ms Dixon's previous medical history and evident frailty, one must consider that whilst basic life support could have been initiated it would be very unlikely to have resulted in a successful outcome. There is a careful balance between ensuring a patient receives medical care and that any care provided will have a meaningful outcome.'*	improving training with our staff and providing the tools to do so. In February 2025 the Home purchased 4 Lifevacs, equipment that can assist during the choking procedure by suctioning food/debris from a person's mouth. These items are not mandatory however they can be of great benefit. All relevant staff have had training from the company to ensure correct usage. We have also provided 'bitesize' sessions to all relevant staff on how to deal with an episode of choking.

	Evidence – Regarding point 1, para 2 in section 5 – Coroner's concerns: *'Despite this, once LAS staff arrived at Acorn Lodge Care Home, the Care Home staff told paramedics that they had been attempting to feed the patient, but the patient started to gasp before any food was given to her, meaning they were unable to feed her.* *This raises concerns about the communication and integrity of the staff members at the Care Home in their provision of care to the patient. I did not receive any reassurance that this concern has been addressed.'* **Our response:** 1. When 999 is called under these circumstances a call handler will remain on the line until the paramedics/first responders have arrived. The ending of that call would be a piece of critical evidence as to the status of the resident at the time of handover to paramedic, however Acorn Lodge have not heard this recording and would politely ask if this evidence was requested? 2. Acorn Lodge documentation on the electronic care planning system (PCS) clearly states the incident as it happened. It states that Mrs Dixon had been fed and how the incident unfolded, also evidencing the order in which the paramedic arrived, the grandson being called to say she was deteriorating as requested/stated by the paramedic, and the last call to her grandson to say she had passed away. The food is also documented on the meal chart on PCS (electronic care planning system). This evidence was not been requested. We attach in Appendix One, relevant excerpts from our electronic care plan system. 3. On the same date of Mrs Dixon's death there is an email from [redacted] (grandson) which clearly acknowledged that Acorn Lodge called him twice, once to say that the paramedic was at the home and that Mrs Dixon was deteriorating and a second time to say she had passed	Staff will be supported to continue to understand the importance of robust and timely documentation.

	away, evidencing that Mrs Dixon was alive at the time of arrival of paramedics. We attach same in Appendix One. 4. The staff members at Acorn Lodge would have been committed to giving reassurance and evidence about their integrity, however there has not to date been an opportunity to do so. No further request for evidence was requested and the staff members were unable to give their account other than statements requested, due to the hearing being held under the R23 rule. 5. There was no opportunity for them to challenge the statements from the LAS as these were only sent to Acorn Lodge 11 days prior to the hearing; on request, the Home was informed there would be no opportunity to challenge.	

Response provided by: [redacted] – Registered Manager, Acorn Lodge Care Home E5 0QP

Signed [redacted] Date 02/06/2025

Appendix One

Care plan notes Acorn Lodge

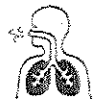
Email of [redacted]

20:06
2 minutes
details ♥

[redacted]
Nurse


Blood pressure 126 over 96 mmHg.
Medical

[redacted] Nurse 20:06 2 minutes details ♥


Respiration 18 rpm.
Medical

[redacted] Nurse 20:06 2 minutes details ♥

Blood O2 89 %.
Medical

[redacted] Nurse 20:06 2 minutes details ♥


Temperature 36.7 C, Staff checked all her vital signs at 18:15.
Handover : Medical

[redacted] Nurse 20:06 2 minutes details ♥

Called again and informed that Ivy Passed away. [redacted] was very aggressive used F ward and said he is on the way.

Handover : Processes Entered via monitor

[redacted] Nurse 19:47 5 minutes details

Informed to Grand son that IVY's condition deteriorating and ambulance crew already with her.at 18.25.

Handover : Processes Entered via monitor

[redacted] Nurse 19:17 5 minutes details

Ambulance called ,at 6.00 Staff went to feed Ivy, she had half of the food, staff left her in upright position after 10minutes staff went to check her ,noticed that, Ivy's breathing pattern changed and she was not responding much, staff called nurse, and inform that her breathing pattern changed, and was not responding well, make her upright position suction done,sp02 checked and it was89%, called ambulance ,oxygen started ,ambulance reached with in 5 minutes . they assessed her and ECG done and informed the staff that her general condition is deteriorating We can inform the family, staff informed her Grand son [redacted] and informed IVY'S CONDITION.AT 18.31 ambulance crew done another ECG and confirmed her death.

Handover : Medical Entered via monitor

[redacted] Nurse 19:14 5 minutes details

Had a glass of water, offered 200 ml, drank 0 ml, was content.

Nutrition eating and drinking

[redacted] Carer 19:13 5 minutes details

Had supper at 18:00 pm, blended boiled potatoes, soup with vegetables she eat half of her food, had meal

[redacted] Carer 19:13 5 minutes

served in their bedroom, had a standard portion, ate a little, was content.

details ♥

Nutrition eating and drinking

6.00 Staff went to feed Ivy, she had half of the food, staff left her in upright position after 10minutes staff went to check her ,noticed that, Ivy's breathing pattern changed and she was not responding much, staff called nurse, and inform that her breathing pattern changed, and was not responding well, make her upright position suction done,sp02 checked and it was89%, called ambulance ,oxygen started ,ambulance reached with in 5 minutes . they assessed her and ECG done and informed the staff that her general condition is deteriorating We can inform the family, staff informed her Grand son [redacted] and informed IVY'S CONDITION.AT 18.31 ambulance crew done another ECG and confirmed her death.

Handover : Medical Entered via monitor

Meals chart

Meal	04/10/2024 *Friday*	05/10/2024 *Saturday*	06/10/2024 *Sunday*	07/10/2024 *Monday*	08/10/2024 *Tuesday*	09/10/2024 *Wednesday*	10/10/2024 *Thursday*
Breakfast	10:15 - Had breakfast Blended porridge and orange and apple blended juice 250ml and	10:19 - Had breakfast a cup of tea porridge, ate all of their food .	10:16 - Had breakfast, had meal served in the dining room, Had some porridge .				

	water 50ml, had meal served in the dining room, ate all of their food .						
Lunch	15:48 - Had lunch boil potato vegetables and meat finish.	13:42 - Had lunch purred vegetables and water, had meal served in the dining room, the vegetarian dish, had a standard portion, ate all of their food , ate all of their dessert.	13:46 - Had lunch Blended macaroni cheese and Blended roast beef and vegetables puree, had meal served in the dining room, had a standard portion, ate all of their food .				
Tea	15:25 - Had tea.						
Supper	18:38 - Had supper Blended mashed potatoes and vegetable pureee and soup, had meal served in their bedroom, had a standard portion, ate all of their food .	18:57 - Had blended potatoes and soup, had meal served in their bedroom, had a standard portion, ate all of their food .	19:13 - Had supper at 18:00pm, blended boiled potatoes, soup with vegetables she eat half of her food, had meal served in their bedroom, had a standard portion, ate a little.				
Other							

Email from Mrs Ivy Dixon's grandson:

From: [redacted]
Sent: 06 October 2024 20:03
To: Acorn Lodge Care Home [redacted]
Subject: Re: Medication

I got a call from your staff today saying that my grandmother's oxygen level was low and could I come to the care home as the ambulance was there. Within a few minutes I got another call saying that my grandmother has pass away.
When I arrived I was told story after story about my grandmother's eating and swallowing. I was also told she was eating fine for breakfast and lunch but had some trouble with supper. She was sat upright patted on the back and some suction was use to get out "some " of he food. I would like the video footage sent to me of the time my grandmother had supper until her untimely death. You can use a website called We Transfer if the file is to big. I was also told that my grandmother's file is all on the computer saved digitally. I would want this sen to me asap as well as her medical reports as well.

Thank you.

Appendix Two

Statement from [redacted]

Addendum Statement of [redacted]

London Ambulance Service
NHS Trust

His Majesty's Coroner

Inner North London Coroners Court

Inquest touching the death of Ms Ivy May Dixon

STATEMENT OF [redacted]

LAS Ref: 15641

I will say as follows:

Background

1. My name is [redacted]; I am the Senior Clinical Lead for Legal Services for the London Ambulance Service NHS Trust. I have responsibility of clinical oversight for cases involving legal services. My main responsibilities include reviewing inquests and clinical claims, representation of the Trust, undertaking incident investigations (including patient safety investigations), Learning from Death reviews via Structured Judgement Reviews and providing clinical opinions. I remain in active clinical practice and regularly undertake shifts as a Paramedic and as Senior Clinical advisor for the Trust.

2. My full qualifications are: Bachelor of Science Degree (Honours) in Paramedic Science. I have been a Paramedic registered with the Health and Care Professions Council (PA34712) since 2012 and am a member of the College of Paramedics. Prior to undertaking this role, I was one of Trusts Quality, Governance and Assurance Managers responsible for North Central Sector as well as a Staff Officer to the Deputy Director of Operations

Purpose of The Report and Materials Examined:

1. Thank you for requesting this clinical statement covering a clinical review of the incident involving Mrs Ivy May Dixon attended to by the London Ambulance Service (LAS) on the 06 October 2024. This statement will provide an overview of clinical care provided to Mrs Dixon,

and will seek to address the following concern raised by HM Coroner:

"Assistant Coroner Potter heard evidence from a registered nurse at Acorn Lodge Care Home (the current Home Manager) that because choking is regarded as a reversible cause, they consider that CPR should have been provided to Mrs Dixon on 6 October 2024."

2. I have had no direct involvement with the care or treatment of Ms Ivy May Dixon.

3. I have reviewed the following documents as part of my review:
    - Electronic call log for CAD 3998 on the 06 October 2024.
    - Audio tape for CAD 3998 on the 06 October 2024.
    - Electronic Patient Care Record (ePCR), case reference number M1XV16390D6E completed on the 06 October 2024 by the attending clinician.
    - Signed statement of Paramedic [redacted], dated 07 January 2025.
    - Signed addendum statement of Paramedic [redacted], dated 13 February 2025.
    - Post Mortem Report dated 07 January 2025, consultant pathologist [redacted].

Timeline of London Ambulance Service Involvement on Scene

For noting: The times provided can be sourced from different references, the times detailed from the control room records are derived from the control room computer system and this is synchronised with an electronic clock for accuracy and recorded on the call log. The defibrillator has an electronic clock, which is checked on service, and when connected to a computer but can show a slight difference to the times on the control room system. In terms of the times an ambulance clinician records on the clinical record this may be from a personal watch or potentially an estimate of the time. Clinical Record timings are often completed following patient handover and require manual manipulation of the automatic clock. This can often lead to discrepancies in relation to the timings on the clinical record.

Time	Time Elapsed	Detail
06 October 2024		
18:15 (hours: minutes)	00:00 (hours: minutes)	A 999 call (CAD 3998) was received and answered immediately. The patient was reported to be breathing and conscious. The call was for a 96-year-old female with the problem description provided as "Choking".

		The call was triaged by Medical Priority Dispatch System (MPDS)[1] and received the determinant "(11D1F) - Abnormal breathing (PARTIAL obstruction)". This received a pre-determined category 1 response profile[2].
18:18	00:03	A Fast Response Unit (FRU), call sign G350, staffed by a Paramedic was dispatched to the incident location. A Double Crewed Ambulance (DCA), call sign K335, staffed by a Newly Qualified Paramedic (NQP) and a Trainee Assistant Ambulance Practitioner (TAAP) was dispatched to the incident location.
18:21	00:06	FRU, call sign G350, arrived on scene at the incident location. Following arrival the clinician was met by care home staff and led to a bedroom where Mrs Dixon was located in a hospital bed. An initial assessment was undertaken, which identified that Ms Dixon was unconscious, not breathing and had no palpable pulse indicating she was critically unwell and in confirmed cardiac arrest. The following history was provided: It was recorded, "Care home staff were attempting to feed the pt [patient] this evening, noted the pt was only eating liquids and was not for solid food. As staff were attempting to feed pt state [sic] that she became unresponsive and made "gasping" sounds therefore were unable to give her any food. Staff were concerned so called 999. As staff were unable to actually feed pt no liquids were given to pt – not a reversible cause. No evidence of vomit or liquids in the airway".
18:29	00:14	G350 contacted the Emergency Operations Centre (EOC) and advised that Ms Dixon was in cardiac arrest and that no further resources were required. K335 was stood down from the incident. The following note was recorded on the log: 'Pat [patient] deceased, DNJAR [sic – DNACPR] in place, NFRR [no further resources required]'
18:31	00:16	A set of observations was recorded as follows: • Respiratory Rate – 0 breaths per minute • Heart Rate – 0 beats per minute • Pupils – 7mm, both fixed (indicating that Mrs Dixons pupils were dilated and not reactive to light) • Glasgow Coma Scale – 3/15 (indicating Mrs Dixon was unconscious) A cardiac rhythm analysis was undertaken which identified that Ms Dixon was asystolic[3]

[1] Medical Priority Dispatch System is a national call taking system which assists call handlers to triage calls and establish a response profile.

[2] Category 1 calls as a cohort of calls have a mean response target of 7 minutes and a 90th centile response time target of 15 minutes. This is a commissioning target for the total number of calls of a specific category and is not assigned to an individual call. Even where an ambulance service is achieving its 90th centile target, there will still be response times for individual calls which fall outside of the target.

[3] Asystole represents total cessation of electrical and mechanical activity of the heart.

		Verification of the fact of death was completed citing a DNCPR was in place and confirmed the patient had no pulse or respirations. All required examinations were completed.

Call Handling and Dispatch

4. It is outside the scope of this review to comment on the handling and accuracy of the 999 call but I note the call was triaged as category 1 which is the highest response profile. With the current information available this appears appropriate.

5. It is noted that the overall response time to the call was 6 minutes.

6. On review an appropriate number and skill of resources were dispatched to the call. The double crewed ambulance was cancelled by the attending clinician following their arrival.

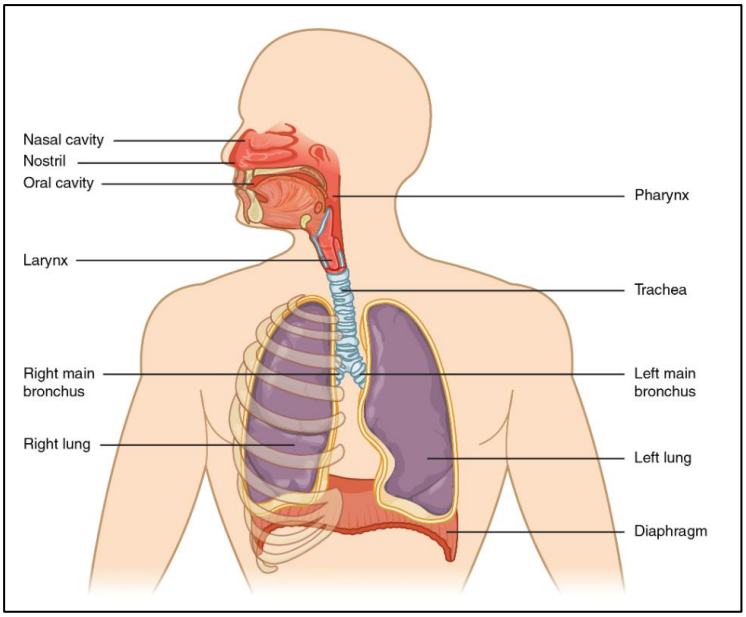
Summary of Clinical Care

7. I note that Ms Dixon was at the time of her death a 96 year-old-female with a history of dementia and hypertension (high blood pressure). The clinical record suggests that she was bed bound and was noted to be on a liquid diet suggesting she had reduced mobility and a level of frailty and likely a poor swallow.

8. I note a provisional cause of death has been provided as:

    1a. Asphyxia
    1b. Choking on Food
    II. Essential hypertension and Type II diabetes mellitus

9. On review of the post mortem I note a key finding indicated that “the tracheo-bronchial tree was obstructed by greenish/grey pureed food”. To assist with understanding, Ms Dixon’s breathing pipe (trachea) was obstructed with pureed food to the point at which the trachea divides into the left and right lung (bronchus). This is outlined in the diagram below.



Management of Ms Dixon

10. On arrival of the clinician, they were promptly shown to the location of Ms Dixon. She was noted to be semi-recumbent in a hospital bed and in receipt of oxygen via a high flow mask. No further treatment was being provided by the care home staff at the time of their arrival. There was no ongoing resuscitation.

11. The clinician undertook a primary survey. This identified that Ms Dixon was unresponsive, was not breathing and had no detectable pulse (indicating there was no palpable heart beat). This indicated that Ms Dixon was in a confirmed cardiac arrest. The clinician confirmed no bystander CPR had been provided prior to their arrival.

12. The clinician ascertained that Ms Dixon had become unresponsive as staff at the home were attempting to feed her, she was noted to have made gasping noises and 999 was contacted. The staff informed the clinician that no food had been provided to Ms Dixon prior their arrival on scene and further that Ms Dixon had a do not attempt cardiopulmonary resuscitation (DNACPR) order in place.

13. The clinician appropriately undertook a visual inspection of Ms Dixons airway from her semi-recumbent position in the hospital bed. This would likely have enabled visualisation to the back of the mouth (oropharynx). On inspection there was no noted food detritus to indicate that Ms Dixon's cause of arrest was choking. In consideration of this along with the fact the staff had advised they had not provide Ms Dixon with any food in conjunction of the

knowledge that Ms Dixon has a DNACPR in place, the clinician made the decision that Ms Dixon was unlikely to be choking and as a result, undertook verification of the fact of death at 18:31 considering the cause of the arrest was likely in line with the DNCPR. No further treatment was provided.

14. Clinical guidelines in relation to presentations of choking when a valid DNACPR is in place are presented within JRCALC (Joint Royal College Ambulance Liaison Committee) guidelines under 'Termination of Resuscitation and Verification of Death in Adults'. This is included below:

> - There will be occasions when a patient who has a DNACPR decision may have a cardiac arrest that is considered unnatural and not in the envisaged circumstances and has a potentially easily reversible cause (e.g. patient has taken an overdose, is choking or has anaphylaxis). All reversible causes should be considered (refer to Section 10 of Advanced Life Support). In these circumstances, resuscitation and rapid conveyance to hospital should be considered, as the cause of the arrest is unrelated to the patient's main clinical problem(s) and could be reversible. In these potentially reversible situations, it is vital to seek urgent senior clinical advice as per local policy. Documented DNACPR decisions are not valid in cases of suicide.

JRCALC, (2022), 'Termination of Resuscitation and Verification of Death in Adults'

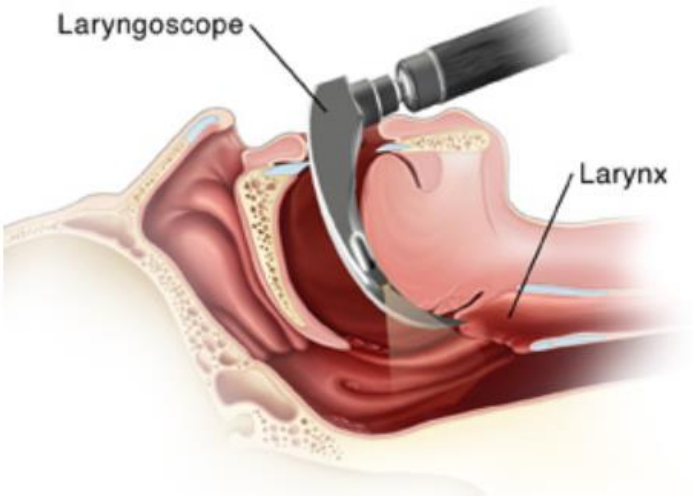
15. Choking is considered a reversible cause, and therefore consideration should be made to clinical treatment. Where a clinician is presented with an unconscious patient as a result of choking, expectations are that LAS clinicians consider national JRCALC guidance which is provided below:

> **Severe Airway Obstruction – Unconscious Patient**
>
> **Adult, Child > 1 year and Infant < 1 year**
>
> - Open the mouth and look for any obvious obstruction.
> - Attempt to visualise the vocal cords with a laryngoscope.
> - If an obstruction is seen and it can be grasped easily, make an attempt to remove it with forceps, or suction.
> - **DO NOT** attempt finger sweeps – these can cause injury and force the object more deeply into the pharynx.
> - If the patient is unconscious or becomes unconscious, begin basic life support (refer to Basic Life Support in Adults and Basic Life Support in Children).
> - If all other measures fail and airway remains obstructed, also consider cricothyroidotomy or surgical airway (not infants) where trained and authorised.
> - During CPR, the patient's mouth should be checked for any foreign body that has been partly expelled each time the airway is opened.

16. In this case, the clinician appropriately undertook a visual inspection of the airway, however, one could considered a further examination with a laryngoscope[4]. Had this occurred it would

[4] A laryngoscope is an instrument consisting of a blade and handle which is inserted into the patients mouth to enable visualisation of the of the larynx and vocal cords. It allows further review of a patient's airway.

have enabled further visualisation of the patient's upper airway to the opening of the larynx (up to the vocal cords). A diagram is provided below to assist with visualisation of this.



17. Whilst this is considered, it is important to note that the use of suction prior to the arrival of the clinician may have removed any blockage or evidence of detritus above the larynx. Further given the description of the blockage, it would not have been possible to visualise any blockage below the vocal cords. In consideration of this there would have been no blockage which the clinician could either have identified or removed.

18. Where a patient has aspirated (where food, liquid or foreign substances) are accidently inhaled into the trachea and lungs (beyond the vocal cords), there is limited treatment options available to the clinicians and where this has occurred, there is limited success in removal.

19. Once the airway has been examined and any obstruction removed, guidance advises that basic life support should be initiated. One is minded to consider that on arrival of the clinician Ms Dixon was in confirmed cardiac arrest. On review of the statements and clinical record provided, there had been no provision of cardio pulmonary resuscitation prior to the arrival of the clinician and the time at which she deteriorated into cardiac arrest was unknown.

20. On review of the information provided, and in consideration of Ms Dixon's previous medical history and evident frailty, once must consider that whilst basic life support could have been initiated it would be very unlikely to have resulted in a successful outcome. There is a careful balance between ensuring a patient receives medical care and that any care provided will have a meaningful outcome.

21. Where a patient has deteriorated into cardiac arrest as a result of choking, the prognosis of a patient is extremely poor. Current data is suggestive of a less than 6% survival rate When you consider this figure in the context of a patient with marked frailty and no immediate option to clear the airway any chance of survival would have been minimal at the most.

22. In consideration of the information provided on the 999 call, the caller advised that Ms Dixon had started choking following being fed, that her oxygen saturations were deteriorating, they had used suction, she had shallow breathing and they had applied oxygen. On review, It is not clear why the information provided to the 999 call handler differed to the information provided to the clinician on scene. Had the clinician been informed of the circumstances outlined on the 999 call, it is not unreasonable to consider that the clinician would have considered the cause of the arrest to be choking but on balance I am not of the view that with no obvious obstruction of the airway this would have changed either any intervention or outcome.

23. The completed clinical record, subsequent clinical statements and discussions with the clinician indicate that at the time of the attendance to Ms Dixon they were aware of the guidance. Whilst this is recognised, there were indications of an obstruction and whilst in my opinion their care was not wholly unreasonable, they have been receptive to feedback. Their verbalised insight and reflection of the attendance to Ms Dixon has been commendable.

I would like to take this opportunity to extend my deepest sympathies to the family and friends of Mrs Dixon and would like to apologise for any distress caused by this statement.

STATEMENT OF TRUTH

I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer.

DECLARATION

I, [redacted] declare that:

I understand that my duty included in my providing written reports and giving evidence is to help the court on the matters within my expertise. I confirm that I have complied with that duty and will continue to comply with it. This report is addressed to the court. I understand that this duty overrides any obligation to London Ambulance Service NHS Trust.

Name:

Signature:

[redacted]

Date: 24th February 2025

London Ambulance Service NHS Trust

Confidential

IN THE PROPOSED MATTER OF AN INQUEST INTO THE DEATH OF

Ivy May Dixon

WITNESS STATEMENT OF [redacted]

I, [redacted] WILL SAY as follows:

1. I am a Band 6 paramedic and I have been working for the London Ambulance Service (LAS) since the 1st of July 2021. My station/base is Cody Road Ambulance Station.
2. I have been requested to complete a witness statement by the Coroner. It has been requested that I cover when I arrived on scene to when the deceased was left in the care of others.
3. I have referred to the ePCR to prepare this statement. No other documents or references have been used.
4. On the 6th of October 2024 I was working under the call sign of G350 out of Homerton Ambulance Station. At 18:18 I was dispatched to CAD 3998, it was given as category 1 call with the chief complaint of choking with abnormal breathing.
5. I arrived on scene at 18:21 and was met by care home staff outside. I was led inside and into the patients bedroom, the patient was in a hospital bed in a semi-recumbent position with high flow oxygen mask on the patients face.
6. In the room was two care home staff and a nurse.
7. When I assessed the patient they were not breathing and did not have a pulse. I asked the staff what had happened and they had stated that they were attempting to feed the patient thick liquids when she became unresponsive and made a gasping sound.

8. I clarified with the staff that they were unable to feed the patient any food. No food was given to patient.
9. Staff stated that is when they called 999.
10. Staff on scene including the registered nurse stated that no CPR was commenced prior to LAS arrival.
11. The nurse who was present stated that the patient had a DNAR (do not attempt resuscitation), she presented the valid DNAR to myself.
12. I assessed the patient's airway and no food, liquid or secretions present, confirmed with staff that they were unable to feed patient as she was unconscious.
13. To assess the patient's airway I opened her mouth and visually inspected the airway which was clear and no evidence of food was found.
14. There is no official mention of the processes/procedures for airway management in patients who have suspected choking in the LAS Airway Management Policy OP077.
15. In our JRCALC (Joint Royal Colleges Ambulance Liaison Committee) guidelines it advises that for an unconscious patient with a severe airway obstruction you begin CPR. To manage the airway you open the mouth and look for any obvious obstruction. Then attempt to visualise the vocal cords with a laryngoscope. If an obstruction is seen and it can be grasped easily, make an attempt to remove it with forceps, or suction.
16. As the staff on scene specifically stated to myself that they were unable to feed the patient, there was a low clinical suspicion of choking so CPR was not commenced.
17. With LAS guidance if the cause of cardiac arrest was choking it is deemed as a reversible cause and BLS should be started even if the patient has a DNACPR.
18. As the patient was not breathing, did not have a pulse and had a valid DNACPR no BLS (basic life support) was attempted.
19. I updated EOC (emergency operational centre) stating that there was no further resources required.
20. I confirmed ROLE (recognition of life extinct) at 18:31.
21. I then left the patient in the care of both the nurse and two further care home staff in the patient's bedroom and completed my paperwork in my vehicle.

Statement of Truth

The contents of this statement are true to the best of my knowledge and belief.

Signed [redacted]……..

Dated: ....13/02/2025...