Prevention of Future Deaths Report: Ivy May DIXON
(Date of death: 6 October 2024)

	Regulation 28 Report to Prevent Future Deaths
	THIS REPORT IS BEING SENT TO: 1. The Directors Lukka Care Homes Limited Macneil House 9 – 17 Lodge Lane London N12 8JH
1	**CORONER** I am Ian Potter, assistant coroner for Inner North 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.
3	**INVESTIGATION and INQUEST** On 11 October 2024, an investigation was commenced into the death of Ivy May DIXON, aged 96 years at the time of her death. The investigation concluded at the end of an inquest heard by me on 28 January and 28 March 2025. I conclusion of the inquest was a short narrative conclusion. The medical cause of death was: 1a asphyxia 1b choking on food II essential hypertension and type 2 diabetes mellitus
4	**CIRCUMSTANCES OF DEATH** The circumstances of Mrs Dixon's death are encapsulated within 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 6 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."
5	**CORONER'S CONCERNS** During the course of my investigation and 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 healthcare assistant who had been with Mrs Dixon on the evening of 6 October 2024, clearly referred in her statement to the patient having been fed. Shortly thereafter the healthcare assistant heard "a noise" coming from the patient's chest and so she called for the assistance of a nearby nurse. Two nurses attended and made the reasonable assumption that the patient was choking. Treatment was administered and a set of vital observations showed that the patient's oxygen saturations were 87%. On this basis, nursing staff called for an emergency ambulance: the London Ambulance Service (LAS) call handler was told that the patient was "choking" albeit she was breathing and conscious at that time. 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. 2. While the patient was breathing and conscious at the time of the 999 call, when LAS staff attended six minutes later, the patient was not conscious, not breathing, had no palpable pulse, and was critically unwell in confirmed cardiac arrest. However, despite this, staff from the Care Home were not undertaking CPR. The DNACPR would not have applied in this case, because choking is a potentially reversible cause of cardiac arrest, which the Care Home's manager confirmed in her evidence.

	This raises the concern that staff (healthcare assistants and nursing staff) at the Care Home may have previously unidentified training needs and/or lacked the clinical skills/knowledge to provide emergency care.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you 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 4 June 2025. I, the coroner, may extend the period. Your response must contain details of the 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: The Family of Mrs Dixon. In addition, I have sent a copy of my report to the following, for information: The Care Quality Commission I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted form or summary form. She may send a copy of this report to any person who she 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	**Ian Potter** HM Assistant Coroner, Inner North London 9 April 2025