ASPRAY HOUSE
Care and understanding with humanity

Mr Graeme Irvine – His Majesty's Senior Coroner for
East London
The Coroner's Office
East London Coroner's Court
Queens Road
Walthamstow
E17 8QP

19 August 2025

Dear Sir,

The Inquest Touching the Death of Mrs Madeline Reding (DoB: 21/11/1944)
Regulation 28 Report – Action to Prevent Future Deaths – Aspray House Nursing Home dated 21 July 2025 (the "Report")
[redacted]

I refer to the above and write to provide Aspray House's response to the Regulation 28 Report to Prevent Future Deaths, received on 21 July 2025.

The Report confirms that the due date for our response is 56 days from the Report, so 15 September 2025.

This response is made under paragraph 7(2) of Schedule 5 of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. We understand the response must contain detail of action taken or proposed to be taken, setting out a timetable for action. Otherwise, we must explain why no action is proposed.

The Coroner's concerns are as follows: -

1. The inquest found that staff responses to the developing emergency were delayed and disorganised. Despite four registered nurses being present at the scene, no effective leadership of the emergency response was witnessed.
2. An emergency alarm was not sounded promptly.
3. A 999 call was not made immediately on discovering Mrs Reding was unresponsive.
4. Despite specific instructions to commence CPR being given on three separate occasions by a London Ambulance Service call dispatch handler, resuscitation was not commenced by a registered nurse as she did not appreciate that a "Do not attempt cardio-pulmonary resuscitation order" would not apply to the patient in the event that the cardiac arrest was due to a reversible cause, such as choking.
5. First aid that was administered was ineffective.
    a. Back slaps were weak.
    b. Abdominal thrusts were not attempted.
    c. Chest compressions were only commenced over ten minutes after Mrs reding was found to have stopped breathing.

Post incident actions

We have addressed the First Concern in the Report as below: -

The two Duty Lead nurses involved, along with all permanent and agency staff who work at Aspray House have been given extensive training (which we will address in further detail below), whilst the Home Manager and Deputy Operations Manager employed at the time who were involved in the incident (who were also registered nurses at that time) have been replaced with new management.

We have addressed the Second, Third, Fourth and Fifth Concerns in the Report as below:-

Policies were already in place prior to the incident in respect of *Swallowing Difficulties* and *Basic Life support, Resuscitation and DNARCPR* which were not followed by the staff. These policies included instructions to dial 999, to give up to five back slaps followed by up to five abdominal thrusts, commence CPR if unresponsive, and use de-choking equipment (if trained). Additionally, all nursing and care staff were required to undertake annual First Aid Practical training and annual training on how and when to the use of Life-Vac de-choker equipment in choking situations.

Immediately following the incident, an urgent flash Lessons Learnt training session was held with all nursing staff (including the management nurses present at the incident) on 23 May 2025 to reinforce the existing *Swallowing Difficulties* policy and *Basic Life support, Resuscitation and DNARCPR* policies and the procedures to be followed in the event of a choking incident. Both policies were subsequently reviewed on 31 July 2024 and noted to be compliant with Resuscitation Council, Royal College of Nursing and CQC guidance.

Extensive anti-choking and First Aid training followed with all staff, both permanent and agency and including care staff and non-care staff, where all staff received group training along with individual competency testing where this incident was discussed and the policy and procedures were reinforced to prevent a recurrence. Further refresher training was held three months later to reinforce the policies and lessons learnt.

Senior management designed a simple to follow colour coded Choking Flow Chart in October 2024 which is compliant with current guidance and which has been placed on display in all nursing stations throughout Aspray House reinforcing the policy, procedure and expectations of how all staff should deal with choking situations – including highlighting that CPR must be attempted if suitable even on residents with a DNAR in place. This has been supplemented with a pictorial Choking First Aid poster for universal understanding which has been displayed in all dining areas.

In October 2024, Aspray House also purchased an Act Fast Anti Choking Trainer Vest for use in practical training to ensure that all staff are proficient in back slaps and abdominal thrusts. Students wear the Choking Vest to learn the correct manoeuvres which when performed correctly shoots a foam plug into the air. It also includes a foam back slap pad for practicing effective back slaps. Thus, making instruction realistic and leaving participants confident in their actions and their response to a genuine choking incident should one occur.

Following a subsequent meeting with the Local Authority and taking on board its concerns that all post-incident training competences and assessments were conducted in-house, Aspray House also engaged a private training provider – Michael Hughes Training - to assess its staffs' competency in choking training. This training was undertaken on a two-day rotation on 21 and 31 March 2025 with individual assessments conducted with all 73 staff members working at the home (both permanent and agency staff). We confirm that all staff members successfully passed the course.

Aspray House also purchased its own defibrillator on 22 May 2025 which is located within the Manager's office on the first floor of the Home. Posters displaying its location are displayed beside the Choking First Aid poster in all dining areas with all staff having been given guidance on its use.

Aspray House noted the Coroner's concerns at the Inquest that even where a choking risk assessment had been carried out and a resident not identified as having a choking risk, that a diagnosis of dementia could cause a risk of choking. Immediately after the inquest concluded, Aspray House implemented warnings being added to the Care Plans for every resident with a dementia diagnosis the following day. This new warning is displayed on the first page of a patient's Care Notes on the hand-held PCS devices used by all staff and highlights a risk of choking (regardless of the score achieved against a standard choking risk assessment) due to dementia and that choking is a potentially reversible situation and that CPR should be commenced if suitable.

All staff are now given choking training on a 6-monthly basis regardless of their role (including agency staff) – whether they be nurses, carers, cooks, housekeepers, maintenance staff etc.

LifeVac training and Basic First Aid training is also mandatory for all staff (employees and agency) and is to be completed before a new staff member commences work with residents and are both refreshed annually. All pre-existing staff must refresh their LifeVac and Basic First Aid training on an annual basis and a training matrix is held to ensure compliance.
In summary, we provide a list of actions taken with the relevant dates for each and evidence of such attached under Exhibit "**AM1**" as follows: -

Action Taken	**Date of Action**	**Exhibit AM1 Page No.**
Urgent Flash Lessons Learnt training with all nursing staff. Disseminated to all staff via flash daily meetings.	23/05/2024	1
Face to Face Anti-choking training conducted with all staff (nursing, care, housekeeping, maintenance, activities staff).	24/06/2024 – 03/07/2024	2
One to one choking competency assessments undertaken on all care staff (including agency staff) who assist residents at mealtimes.	02/07/2024 – 13/09/2024	3 - 5
Swallowing Difficulties policy reviewed.	31/07/2024	6 - 10

Basic Life support, Resuscitation and DNARCPR policy reviewed.	31/07/2024	11 - 18
Choking Act Fast refresher training held for all nursing and care staff and follow up training on Lessons Learnt.	14/10/2024 - 15/10/2024	19 - 20
Choking Flow Chart designed and placed in all nursing stations.	October 2024	21
Pictorial Choking First aid posters purchased and placed in all dining areas.	October 2024	22
Act Fast Anti Choking Vest purchased for use practical training in back slaps and abdominal thrusts.	21/10/2024	23 - 27
External Choking (Adult) Training undertaken for all staff with Michael Hughes Training.	21/03/2025 – 31/03/2025	28 - 29
Defibrillator purchased for Aspray House and located in the Manager's office with signage through all dining areas.	22/05/2025	30
Care Notes for all residents with a dementia diagnosis updated to add a risk of choking or aspiration (regardless of their standard choking risk assessment score), and that choking is a potentially reversible situation and CPR should be commenced if required.	16.07.2025	31
Staff Training Matrix (names redacted)	18.08.2025	32 - 40

As stated at the Inquest, the management involved are no longer working at Aspray House and I would like to assure you their inactions and those of the two nurses on duty on the day of the incident in no way reflect the high standard of care that staff at Aspray House are trained to deliver.

The entire staff team have been shocked and saddened by the events that led to the death of Mrs Reding and have embraced the training that has been reinforced and continues to be reinforced to mitigate the risk of this happening again in the future.

Mindful of the changes that we have implemented above, and which will be continuously monitored and reviewed going forward, we believe that all our residents are appropriately monitored, particularly dementia patients during mealtimes who are not left unattended and are closely supervised, and that the environment that they live in is safe with staff trained to a high standard.

We hope we have addressed and allayed the concerns of the Coroner in our response above.

Yours sincerely,

[redacted]
Operations Manager and RGN