MR G IRVINE
SENIOR CORONER
EAST LONDON
East London Coroner's Court, Queens Road Walthamstow, E17 8QP
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REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Ref: 27804673

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** [redacted] Head of Operations, Aspray House Nursing Home, 481 Lea Bridge Road, Leyton, London, E10 7EB **Sent via email:** [redacted]
1	**CORONER** I am Graeme Irvine, senior coroner, for the coroner area of East 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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 25th May 2025 this Court commenced an investigation into the death of Madeline Reding aged 79 years. Following an autopsy Mrs Reding's medical cause of death was determined as; *1a Acute Respiratory Failure* *1b Aspiration Of Food Material* *II Dementia And Frailty Of Old Age* An inquest was opened on 28/05/2024 which concluded on 15th July 2025 after a two-day hearing

	The Inquest resulted in a narrative conclusion; Narrative conclusion: *Madeline Reding died on the afternoon of 17th May 2024 in her nursing home. Mrs Reding sustained a respiratory arrest when she regurgitated food she had eaten at lunch.*
4	**CIRCUMSTANCES OF THE DEATH** Mrs Reding was a resident in a nursing home who suffered from advanced vascular dementia, she required 24 hr 1:1 care. On the 17th May 2024 Mrs Reding ate lunch in the 2nd floor lounge of the nursing home. After lunch she became unwell, vomited and developed an upper airway obstruction. Mrs Reding lost consciousness and subsequently sustained a cardiac arrest
5	**CORONER'S CONCERNS** During the course of 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 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.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] 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 by **15th September 2025.** I, the coroner, may extend the period. 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.
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 Reding, the Care Quality Commission, the Nursing & Midwifery Council. I have also sent it to the local Director of Public Health who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**[DATE] 21st July 2025 [SIGNED BY CORONER]**