REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

1.	**CORONER** I am Lydia Brown, Senior Coroner, for the coroner area of West London.
2.	**DATE OF REPORT** **8 May 2026**
3.	**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.
4.	**THIS REPORT IS BEING SENT TO** 1. Choice Support 2. NHS South West London ICB 3. NHS England You are under a duty to respond to this report within 56 days of the date of this report, namely by 3 July 2026. I, the coroner, may extend the period if an appropriate application is made.
5.	**YOUR RESPONSE** 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.

6.	**SUMMARY OF CORONER'S CONCERN** **An AED (Defibrillator) was not immediately available in a healthcare setting responsible for adults with high tier complex needs where at least one of the residents was at high risk of choking or aspiration.** **There was no individualised care plan to set out details of the appropriate First Aid response including necessary equipment required to be available and the appropriateness of conducting CPR** **Registered nursing staff were not adequately trained to carry out required basic life support when an emergency arose.**
7.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
8.	**INVESTIGATION AND INQUEST** On 23 January 2025, I commenced an investigation into the death of Jake Daniel Taylor, aged 19 years. The medical cause of death was unascertained although considered to be due to natural causes. Jake died on 20 January 2025 in Kingston hospital after he suffered a cardiac arrest in his care home on 16 January. **Conclusion** Death due to natural causes, but the reason for the collapse could not be medically determined.
9.	**CIRCUMSTANCES OF DEATH** The cause of the cardiac arrest could not be ascertained. Jake required 24 hour care, had global developmental delay, cerebral palsy and epilepsy and was at high risk of aspiration and choking. On the day of the arrest he was being cared for in accordance with his 1:1 needs, but when he collapsed there were delays in providing appropriate first aid, as necessary equipment including a defibrillator was not immediately available and chest compressions were not commenced until the arrival of the emergency responder, even though the staff present were first aid trained and had nursing qualifications. A "do not attempt CPR" had been discussed variously between his family, carers, paediatrician (however he had now transitioned into adult services), but this had not been fully considered or implemented. There was no plan for the individualised first aid response that Jake required due to his body posture and known osteopenia.

	Due to uncertainties of staff as to how to proceed, there were no beneficial interventions until the arrival of the London Ambulance Service, some 7 minutes after the 999 call was initiated, when all possible interventions were conducted. By this time Jake had sustained an unsurvivable hypoxic brain injury. It could not be concluded if earlier interventions would have changed the outcome, but opportunities to do so were potentially lost.
10.	**CORONER'S CONCERNS** During the course of the inquest I heard evidence 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: No planning for this foreseeable emergency. Inadequate staff training (to always conduct CPR if no decision to the contrary) No defibrillator on site and staff misunderstanding of the function of a defibrillator. No airway training and equipment although Registered Nursing staff have this within their competencies. I consider that individual emergency planning for those service users with recognised high tier needs and life-threatening risk profiles is essential to ensure best possible outcomes and care tailored to their needs. Medical emergencies in this cohort of patients are predictable but are likely to happen suddenly and unexpectedly. In this case the staff were not able to respond and their evidence to the court demonstrated that they felt unprepared and uncertain about what to do. This is a situation that could be replicated throughout the services that care for individuals such as Jake. Those commissioning the services should consider if the individual emergency care planning is comprehensive and complete and reviewed where appropriate.
11.	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: Interested Persons:- 1. The family of Jake 2.Richmond and Kingston NHS Foundation Trust 3.Choice Support It is addressed to those named in paragraph 3

	I also send it to those who may be interested in it Resuscitation Council UK [redacted](Jakes GP) I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
	[redacted] **Mrs Lydia Brown** **HM Senior Coroner** **West London**