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Sally Robinson

HM Assistant Coroner

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28 August 2026

Care Quality Commission
[redacted]

Dear HM Assistant Coroner Robinson

Prevention of future death report following inquest into the death of Phillip Quelch

Thank you for bringing the Regulation 28 prevention of future death report to the attention of the Care Quality Commission (CQC) following the inquest into the sad death of Phillip Quelch who died on 5 July 2025 at Crouched Friars Care Home ('Crouched Friars'). We acknowledge the concerns you have raised and appreciate the opportunity to respond.

We would like to express our sincere condolences to the family of Mr Quelch.

We note the legal requirement upon CQC to respond to your report within 56 days of the date of the report, namely by 1 September 2026.

The registered provider of Crouched Friars is SA & JO Care Limited. They have been registered with CQC since 13 October 2011. The provider is registered for the following regulated activity: Accommodation for persons who require nursing or personal care. The provider is not permitted to provide nursing care at this location.

Crouched Friars was inspected on 15 and 27 September 2022 and was rated Good in key questions: Safe, Effective, Responsive and Well Led, and rated Good overall. Caring was not reviewed. Improvements had been made following the previous inspection carried out in May 2021 and they were not in breach of Regulations.

CQC received a statutory notification of a death in a care home from Crouched Friars on 15 July 2025 informing us of an unexpected death. Cause of death at that time was not known. CQC requested the registered manager for Crouched Friars to advise CQC of the cause of death as soon as it was known. On 6 October 2025, the deputy manager of Crouched Friars told CQC they had been informed the coroner had opened a coronial investigation into the death of Mr Quelch and that the postmortem concluded the cause of death to be from an airway obstruction caused by food stuck around epiglottis.

CQC has responsibility for prosecuting registered persons (this includes registered providers and registered managers), where it can be shown to the required evidential standard that failures to provide safe care and treatment led to a person using services experiencing avoidable harm, or placed them at serious risk of such harm (contrary to Regulations 12(1) and 22(2), Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

In such cases CQC can only hold the registered person(s) to account (registered provider and registered manager), we are unable to hold individuals such as nursing staff and care workers to account.

Preliminary enquiries were commenced into the circumstances surrounding Mr Quelch's death. The coroner granted CQC interested person status and shared the fully completed evidence bundle with us on 5 May 2026. We considered if there was sufficient evidence to take further action relating to Regulation 12(1) Safe care and treatment in relation to Mr Quelch.

Following a full review of all the evidence CQC concluded we did not have grounds to begin a criminal investigation.

CQC will continue to monitor the service utilising information obtained from our insight data as well as other stakeholders such as the local authority. We will use our regulatory processes to assess, and where necessary civil enforcement pathway to drive improvement.

Regulatory assessments will be undertaken when and where required. Once an assessment is completed a report will be published on the CQC website with our findings.

Matters of Concern

1. **Mr Quelch was not consistently supervised whilst he was eating his meals**

CQC contacted Crouched Friars to request written confirmation and evidence of the action they have taken to date following this death and any additional action they intend to take in response to the prevention of future death report.

We received a response by return, Monday 27 July 2026 which informed us of the following:

- From extensive review and reflection on the circumstances surrounding the sad death of Mr Phillip Quelch lessons have been learned.
- This led to the registered manager, Paulina Eagle developing 'The Phillip Promise'. A comprehensive framework to improve their approach to delivering person-centered, safe, responsive and consistent care and support to people with or developing swallowing difficulties and at risk of choking.

On review of the document, we contacted Crouched Friars to revise the Phillip Promise policy to include:

- A policy for people who eat alone in their bedrooms
- Risk assessments for those people eating alone in their bedrooms – particularly those at risk.
- More detail on the type and level of supervision required as supervision can be interpreted differently by individuals.

The registered manager for Crouched Friars has since reviewed and revised the first version of the Phillip Promise Policy to include all the above. The policy and implementation of it will ensure the correct safeguarding measures are in place to protect people and reduce the risk of choking.

CQC will continue to monitor the provider's compliance with regulatory standards and ensure that learning from this case is embedded into practice. We remain committed to supporting improvement in patient safety and care quality across all services.

2. **Mr Quelch was subject to a DOLS. It was not clear at inquest what involvement there had been with the Best Interests Assessor.**

3. **If a Best Interests Assessor notes an adult is at risk of choking, then they should check a choking risk assessment has been carried out and there should be an assessment of capacity under the Mental Health Capacity Act.**

4. **If these have not been done, then The Best Interests Assessor should consider a recommendation under the DOLS that the adult should receive appropriate guidance and support when accessing nutrition. It was not clear whether these steps had been taken in Mr Quelch's case and what the communication was between the Best Interests Assessor and the residential home.**

CQC has considered points 2, 3 and 4. CQC notes that this Prevention of Future Deaths has been sent to Essex local authority Adult Social Care. CQC considers they may be of greater assistance in addressing these aspects of your concerns.

5. **The SALT referral was closed despite Mr Quelch having co-morbidities which were degenerative in nature and likely to lead to SALT issues in the future.**

We would expect SALT services to have effective processes in place to assess, monitor and manage swallowing risks, with decisions regarding assessment and

discharge based on the person's needs and supported by appropriate documentation and clinical judgement.

We have ascertained from the East Suffolk and North Essex NHS Foundation Trust (ESNEFT) that a referral was made, by the care home, on 17 December 2024. This followed Mr Quelch choking on a wrap on that same day and required emergency intervention. It was also noted that Mr Quelch had learning disabilities and epilepsy.

The referral was triaged by the SALT team who documented Mr Quelch had a low level of complexity and sought further information from the care home. At this point the care home noted this was an isolated incident. Written guidance was provided to the care home, along with recommendations to keep a cough diary and avoid high risk foods for example.

On 23rd January 2025 the SALT team sought an update from the care home. The care home staff member spoken with advised the SALT team the concerns were an isolated incident and they were happy for Mr Quelch to be discharged. A discharge letter was sent to the GP.

The SALT team have reflected on their management of the referral of Mr Quelch to their service. They have identified that they could have asked for further information about the cough diary it was recommended the care home maintain. They have identified greater detail in recording how the available information informed the clinical decisions would have been beneficial. We will take account of this reflection in our ongoing monitoring and regulation of the service.

Yours sincerely

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Deputy Director East of England Adult Social Care
Care Quality Commission