REGULATION 29 RESPONSE TO A REPORT ON ACTION TO PREVENT FUTURE DEATHS

Please do not include any living person names in this document, in accordance with the Chief Coroner's publication policy PDF.

THIS RESPONSE IS BEING SENT TO:

The Senior Coroner, [X] for the Coroner Area Essex in response to a '**REPORT TO PREVENT FUTURE DEATH REGULATION 28**' following an investigation into the death of **Philip Andrew QUELCH**, and an inquest that concluded on **08 May 2026**.

1.	**RESPONDENT** In line with our duty under Regulation 29 of the Coroners (Investigations) Regulations 2013, **NAME** provides this response within 56 days of the date of the Report to Prevent Future Deaths or any extension granted.
2.	**DATE OF RESPONSE** **24/07/2026**
3.	**CONFIRMATION OF CORONER'S MATTERS OF CONCERN** The **MATTERS OF CONCERN** were identified in the report are as follows: During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will 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) Mr Quelch was not consistently supervised whilst he was eating his meals. (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. (5) The SALT referral was closed despite Mr Quelch having a co morbidities which were degenerative in nature and likely to lead to SALT issues in the future.
4.	**DETAILS OF ACTION TAKEN,** how has the concern been addressed. [If no action is proposed please explain why here. If you feel that the response should not have been sent to you, please state this]. *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 death of Mr Phillip Quelch had a profound impact on everyone at Crouched Friars Residential Home. We remain deeply saddened by the circumstances surrounding his death and sincerely regret that we were unable to prevent this tragic event. As an organisation, we have reflected extensively on what happened and have used this as an opportunity to strengthen our systems, improve practice and enhance the safety of all residents who require support with eating and drinking. Our commitment is that Phillip's death will leave a lasting legacy by improving care for others. **The Phillip Promise** Following this incident, I developed **The Phillip Promise** – a comprehensive safe eating and drinking framework designed to ensure that every resident at risk of choking receives safe, person-centred and consistent care. The Phillip Promise includes: • A Safe Eating and Drinking Policy.. • Staff guidance on recognising and responding to choking risks. • Clear escalation procedures where there are any concerns regarding swallowing, food textures, hydration or changes in a resident's condition. • Guidance on Mental Capacity Act (MCA), Best Interest decision-making and DoLS where appropriate. • Ongoing competency expectations and continual staff learning. The aim of The Phillip Promise is to ensure that no concern, however small, is overlooked and that residents always receive the safest possible support during mealtimes. **Care Plan and Risk Assessment Review** Following the incident, we completed a comprehensive review of all residents who require support with eating and drinking. This included: • Reviewing every choking risk assessment.

- Reviewing all nutrition and hydration care plans.
- Sending more SALT referrals and discussing the diet levels with the GP while we are awaiting SALT assessment as it can take few weeks or months
- Ensuring all care plans accurately describe the level of support required.
- Confirming that prescribed food textures and fluid consistencies are recorded correctly in line with current SALT recommendations.
- Ensuring care plans clearly state the supervision required, positioning, pace of eating, equipment required and actions to take should a resident deteriorate or show signs of swallowing difficulties.

Staff Learning and Reflection

The circumstances surrounding Mr Quelch's death have been openly discussed during staff meetings, supervisions and team learning sessions.

Staff have been reminded that:

- Every concern relating to eating, drinking or swallowing must be reported immediately.
- Changes in a resident's presentation, appetite, coughing, choking, voice quality or ability to swallow must never be ignored.
- Concerns must be escalated promptly to senior staff and referred to the appropriate healthcare professionals, including Speech and Language Therapy (SALT), where required.
- Accurate documentation and communication between all members of the multidisciplinary team are essential.

This learning has reinforced a culture where speaking up and acting early is expected of every member of staff.

Whole Home Mealtime Support

We have introduced a whole-home approach to mealtimes.

Rather than mealtimes being the responsibility of care staff alone, housekeeping, activities and other non-care colleagues now assist by supporting observation, encouraging residents, providing reassurance and alerting care staff immediately if they notice any concerns.

This approach has increased supervision during meals, improved resident engagement and reduced the likelihood that subtle signs of difficulty are missed.

Ongoing Quality Assurance

To ensure these improvements are sustained, we have introduced ongoing monitoring through:

- Regular audits of eating and drinking care plans.
- Routine reviews of choking risk assessments.
- Mealtime observations.

	• Continued staff training and competency assessments. • Regular discussions during staff meetings and clinical governance reviews. • Immediate review of any incidents, near misses or concerns relating to eating and drinking. Phillip's death has fundamentally changed the way we approach eating and drinking safety within our home. Through **The Phillip Promise**, we are committed to ensuring that every resident receives safe, compassionate and person-centred support, and that the lessons learned from this tragedy continue to improve the quality and safety of care for all those we support. .
5.	**DETAILS OF FURTHER ACTION PROPOSED** *Any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.*
6.	**SIGNATURE**