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 Sally ROBINSON, HM Assistant Coroner, for the coroner area of Essex.
2.	**DATE OF REPORT** 07 July 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. **Crouched Friars Residential Home** 2. **Essex Adult Social Care** 3. **Care Quality Commission** I am also sending this to the family of Mr Philip Quelch. You are under a duty to respond to this report within 56 days of the date of this report, namely by September 01, 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** **See point 10.**
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 9th July 2025 and investigation was commenced into the death of Philip Andrew Quelch aged 56 years. The investigation concluded at the end of the inquest on 8th May 2026, the conclusion of the inquest was accidental death. Philip Quelch was subject to a Deprivation of Liberty Safeguarding Order and was a resident at Crouched Friars Residential Home on Colchester. He had an in-life diagnosis of vascular dementia dn neurofibromatosis which were degenerative conditions. He needed hep with personal care and nutrition. Mr Quelch died after choking on a large piece of ham which was part of his lunch of ham salad at the home. Post mortem examination revealed a large piece of ham obstructing his epiglottis. His medical cause of death was recorded as: 1a. Airway obstruction 1b. Food stuck in epiglottis. 2. Vascular dementia and neurofibromatosis
9.	**CIRCUMSTANCES OF DEATH** Mr Quelch died at Crouched Friars Residential Home in Colchester on 5th July 2025. He lived in the home as there had been safeguarding concerns when he lived in the community. He died as a result of a choking episode whilst eating a meal at the home. Mr Quelch was subject to a Deprivation of Liberty Safeguarding Order. He was to be assisted with meals and as a minimum needed his food cutting up. Family reported he needed help with eating and drinking, and his care notes documented that he was unable to meet his nutritional and hydration needs independently. He preferred to stay in his room and did not particularly enjoy socialising with the other residents as he had said he felt, essentially, he didn't have anything in common with them. Mr Quelch had had a previous episode of choking at the home and had been referred to the SALT team. He did not ever attend an appointment however as

	there was a waiting list and as he had not had any more choking episodes it was decided that the referral could be closed. On the day he died he had chosen a ham salad for his lunch. It appears he was left with his meal and although staff had checked in on him he was subsequently found not to have eaten much but to be unconscious and unresponsive at 15.15 hours, his meal having been delivered between 12.30 and 12.45 and a further check made at 1336 and around 2pm. CPR was commenced both by staff and by paramedics who attended but sadly Mr Quelch could not be revived.
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: 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.
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: *[please do not use individual's names, but instead roles/titles]* • **Crouched Friars Residential Home** • **Care Quality Commission** • **Essex Adult Social Care** • **Family** 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.
12.	**SIGNATURE** [redacted] **Sally ROBINSON** **HM Assistant Coroner for Essex**