H M Senior Coroner for Gloucestershire
Ms Katy Skerrett

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Chief Executive, Ms D Lee, Gloucestershire Hospitals NHS Foundation Trust, Gloucestershire Royal Hospital, Great Western Road, Gloucester, GL1 3NN**
1	**CORONER** I am Katy Skerrett, Senior Coroner for Gloucestershire.
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.
3	**INVESTIGATION and INQUEST** On the 10th April 2018 I commenced an investigation into the death of Jonathan Brett Yates. The investigation concluded at the end of the inquest on the 2nd April 2019. The conclusion of the inquest was a hybrid conclusion of accidental death and a narrative conclusion. The medical cause of death was 1A The effects of aspiration of gastric contents II Oropharyngeal stenosis due to treated oropharyngeal carcinoma with PEG feeding hepatitis steatosis.
4	**CIRCUMSTANCES OF THE DEATH** Jonathan Brett Yates was a 68 year old who lived alone .He had a significant medical history including alcohol dependency, ischaemic heart disease, previous transient ischaemic attack, treatment for squamous cell carcinoma and ongoing swallowing difficulties. He had been fitted with a PEG feeding tube in 2016. On the 17th March 2018 he suffered a fall outside his home which was believed to be alcohol related, and he was admitted to hospital for further investigations. CT imaging ruled out any head injury. On the 19th March 2018 his PEG was fixed and he was referred to a dietician. At approximately 18.30 hours an evening meal was delivered to Mr Yates. He should not have received this meal as he was nil by mouth. Mr Yates was aware of this fact. Mr Yates attempted to eat the food, he choked and food passed into his breathing tube causing him to stop breathing. He suffered a cardiac arrest. Resuscitation attempts resulted in his heart being restarted. However due to his prognosis, further active treatment was not pursued. Palliative care was commenced and Mr Yates passed away at 14.45 hours on the 20th March 2018.
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 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. – How the nutritional status of a patient, in particular when a patient is nil by mouth, is communicated effectively to staff caring for a patient during an admission to hospital.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 4pm 11th June 2019. 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 (1) [redacted] I am also under a duty to send the Chief Coroner a copy of your response. 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 by the Chief Coroner.
9	Dated 16th April 2019 Signature Ms K Skerrett Senior Coroner for Gloucestershire