York and Scarborough
Teaching Hospitals
NHS Foundation Trust

Chief Executive Office
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[redacted], Chief Executive
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18 December 2024

Ms C Cundy
HM Coroner for York & North Yorkshire
By email: [redacted]

Dear Madam

Thank you for raising your concerns as a result of the inquest into the death of Mr Stephen Dulling, following his admission to York District Hospital. York & Scarborough Teaching Hospitals NHS Foundation Trust (the Trust) recognises the seriousness of these findings, and I write to outline the actions we are taking to address the lapses identified. These measures are intended to reduce the risk of recurrence and improve the quality and safety of care provided to our service users.

Coroner's concern:

a) No evidence of any direct inquiry being made of Mr Dulling's primary carer in respect of his nutritional needs, despite Mr Dulling being deemed to lack capacity
b) It being recorded and acted upon that a regular diet was appropriate for Mr Dulling, despite a) above
c) No food chart being implemented and maintained despite the outcome of Mr Dulling's malnutrition risk assessment

It is accepted that the assessment of Mr Dulling's nutritional needs on admission was not detailed enough and that a food chart was not instigated/completed when it should have been.
The Trust's Food, Nutrition and Hydration Policy (available if required) was updated in November 2024. There are currently several assessments, relating to eating and drinking and nutrition, that nursing staff undertake when a patient is admitted. These assessments are not all located in the same place and not as intuitive as they could be. We recognise that this is

not optimal and are in the process of bringing these assessments together into one section of Nucleus (electronic digital nursing record) and this is due to go live in January 2025. We are confident that this will significantly reduce the risk of essential information being overlooked. The Trust recognises the previous poor compliance in this area, as identified in Mr Dulling's case, and this is a focus of current quality improvement project work. The Trust has completed a Patient Safety Incident Investigation (PSII) cluster review of Speech and Language Therapy (SLT) and swallow related incidents. This was presented to the Trust's Serious Incident Group in December 2024 with an associated action plan.

The PSII identified themes around lack of or delayed referral to SLT as well as food and drink given to patients that is not the IDDSI (International Dysphagia Diet Standardisation Initiative) level advised by SLT. The identified actions are incorporated into ongoing improvement work and monitored by the Trust Food, Nutrition and Hydration Steering Group.

Speech and Language Therapists have also led on development of a Sip Testing Standard Operating Procedure (SOP) which was published in November 2024 along with a training video on Nucleus. This identifies patients who should be considered for a sip test and those for whom this is contraindicated, such as those with pre-existing swallowing difficulties.

d) No assessment or escalation of Mr Dulling's refusal of intravenous fluids

Since this incident occurred there is a new fluid assessment, as part of the Nucleus digital patient record, which is completed for all patients. This then prompts appropriate hydration monitoring dependant on the level of clinical need. The Food, Nutrition and Hydration Policy clearly states that when a patient lacks capacity a best interest's decision should be made about ongoing fluid management, in consultation with family or carers.

e) Evidence of a delayed response by a staff nurse to the information that Mr Dulling was choking

It is noted that the HCA (health care assistant) statement said the nurse looking after the patient had a delayed response, but that nurse was in the middle of giving another patient medication and said there was only a brief moment of delay until the patient swallowed their medication before they attended Mr Dulling.

f) The absence of a de-brief of staff involved in the choking incident by a nurse of the requisite level within the period of 72 hours after the event. This, together with the subsequent delay in undertaking and completing the patient safety investigation review, resulted in important gaps in the evidence supplied both to the review and the inquest.

It is to be noted that at the time of the incident the Trust followed its previous policy on incident management. The Trust moved to the new Patient Safety Incident Response Framework (PSIRF) in December 2023. Since that time revised systems and processes have been put in place to record, monitor, review and learn from incidents across the Trust. It is acknowledged the investigation undertaken following this incident was not timely nor optimal. This has been reviewed with the Medicine Care Group and the new policy requiring either hot

debrief or other form of incident response is now in place and is being used to proper effect. The Medicine Care Group has a dedicated Clinical Governance Team who review all reported patient safety events on a daily basis, appropriate learning responses identified and requested, and any severe or moderate harm patient safety events escalated to the Care Group quadrumvirate.

Conclusion

We hope that this information provides you with assurance that the Trust has learned from this incident and have refined our procedures as a result. This will continue to be monitored carefully through our governance and assurance structures.

Yours sincerely

[redacted]

[redacted]

Chief Executive