Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Chief Executive, Tees Esk and Wear Valley NHS Foundation Trust** **2 Chief Executive, York and Scarborough Teaching Hospitals NHS Foundation Trust**
1	**CORONER** I am Catherine CUNDY, Area Coroner for the coroner area of North Yorkshire and York
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 11 September 2023 I commenced an investigation into the death of Stephen Frederick DULLING aged 69. The investigation concluded at the end of the inquest on 07 October 2024. The conclusion of the inquest was that: Stephen Frederick Dulling died from aspiration pneumonia as a consequence of an inappropriate diet as a hospital in-patient at York District Hospital.
4	**CIRCUMSTANCES OF THE DEATH** On the 31st of August 2023 Stephen Frederick Dulling, who had Parkinson's Disease, symptoms of dementia and attendant swallowing problems, was admitted to the Acute Medical Unit of York District Hospital. On the morning of the 2nd of September 2023 Mr Dulling was eating toast for breakfast when he started to choke and went into cardiac arrest. He was subsequently found to have copious amounts of toast in his airway and gastric contents in his lungs leading to aspiration pneumonia. Mr Dulling died at the hospital on the 4th of September 2023.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters 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: (brief summary of matters of concern) **In respect of Tees Esk and Wear Valley NHS Foundation Trust** - 1. I heard evidence that on 29 August 2023, the day after Mr Dulling had been assessed at home by two members of the Crisis Team, his wife contacted the All Age Crisis Line number she had been given. She spoke to a clinician from the Crisis Team and reported that she and her husband were outside their home address, he was angry and distressed and she needed help. The advice given to Mrs Dulling was to call the police if she was concerned for her safety. Mrs Dulling ended the call frustrated at the lack of practical

	advice and assistance. 2. Mr Dulling had been deemed to present a risk of harm to himself and others when assessed by Crisis Team members on 28 August 2023. My concern is that the call did not establish whether this risk had increased, such that Mental Health Act detention or other emergency intervention should be considered, nor offer practical advice to Mrs Dulling about taking her husband to an acute hospital or calling an ambulance, nor explain what assistance it was considered or anticipated could be provided by the police. 3. My concern is that a repetition of such a limited response could present a risk of future deaths to others. **In respect of York & Scarborough Teaching Hospitals NHS Foundation Trust** – 4. I heard evidence of a number of omissions and lapses in the care afforded Mr Dulling by registered nurses during his admission to York District Hospital. My concerns relate to the following findings – 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; d) No assessment or escalation of Mr Dulling's refusal of intravenous fluids; e) Evidence of a delayed response by a staff nurse to the information that Mr Dulling was choking; 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. 5. My concern is that the above reflects a series of lapses in basic nursing care identified in respect of a single patient, a repetition of any of which could present a risk of future deaths to others.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) 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 December 09, 2024. 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 [redacted]

	[redacted] I have also sent it to **Department of Health & Social Care - Prevention of Future Death Reporting** who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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: 14/10/2024**  **Catherine CUNDY** **Area Coroner for** **North Yorkshire and York**