University Hospitals Birmingham
NHS Foundation Trust

Queen Elizabeth Hospital Birmingham
Mindelsohn Way
Edgbaston
Birmingham B15 2GW

[redacted]

9th December 2025

For the attention of Mr David Reid
HM Senior Coroner for Worcestershire

[redacted]

Dear Mr Reid

Inquest touching the death of William Roath
Response to Regulation 28 Report to prevent future deaths

I am writing in response to the Regulation 28 notice issued following the conclusion of the Inquest on 13 October 2025 touching the death of Mr Roath who died at the Worcestershire Royal Hospital on the 12/12/24.

We have carefully considered the concerns raised within your report to prevent future deaths and would respond as follows.

University Hospitals Birmingham NHS Foundation Trust was deeply sorry to learn of the death of Mr Roath following his discharge from Queen Elizabeth Hospital Birmingham and transfer to Worcester Royal Infirmary on 28th November 2024.

The inquest into his death, held 13th October 2025, concluded that Mr Roath died by accidental death *following a fall down steps…. He suffered skull fractures and a traumatic brain injury and went on to suffer a number of episodes of aspiration pneumonia. He was transferred to Worcester …. but deteriorated further, most likely as a consequence of further aspiration pneumonia*.

The inquest heard that Mr Roath had initially been nil by mouth but after an assessment by the Speech and Language Team (SALT) on 19th October 2024, he was cleared to receive a textured diet in bite sized pieces. Further concerns were raised about Mr Roath's swallow on 20th October and, regrettably, 5 days elapsed before another SALT referral was made. When Mr Roath was reviewed by SALT on 25th October, his swallow was deemed unsafe. In the intervening 5 days, Mr Roath had continued to receive an oral diet intermittently and he had developed and been treated for a presumed aspiration pneumonia. He initially improved and was transferred to Worcester for ongoing care but sadly succumbed to his illness. The Trust's witnesses highlighted that aside from his risk of aspiration, Mr Roath had remained at significant risk of death as a direct result of his traumatic brain injury and its sequelae.

The inquest heard that UHB had put in place measures to ensure that nursing staff and healthcare assistants would not repeat the identified omissions relating to the safe management of swallowing problems and risk of aspiration. In the case of medical staff, however, based on the evidence presented at inquest, insufficient action appeared to have been taken to prevent a recurrence of this incident.

University Hospitals Birmingham wishes to assure the court that its policies explicitly identify the role of all patient facing staff, including doctors, in managing patients with swallowing problems and who are at risk of aspiration. The Trust also has monitoring processes in place to ensure that swallowing-related patient safety incidents are identified.

Responsibilities and monitoring processes are outlined in the Trust Policies:

Controlled Document 1201 "Dysphagia Management Standard Operating Procedure" (SOP) (Current: April 2023- April 2026)

6.2.2 Consultant and Medical Team. All clinical decisions regarding dysphagia management must be agreed by the clinical team, the consultant has overall responsibility for the patient's care.

Controlled Document 1209 "Nil by Mouth Standard Operating Procedure" V2 (Current: April 2023- April 2026)

Section 4: Implementation and monitoring

It is the clinical responsibility of the whole team looking after the patient who is NBM (Nil By Mouth) to ensure appropriate and adequate nutrition, hydration and medicine administration is actioned in a timely way from the point the patient is advised to be nil by mouth.

Section 11:

The controlled document lead (Consultant SALT) will lead the audit of the SOP. The audit will be undertaken in accordance with the review date and will include:

- Adherence to the SOP
- Any untoward incidents or complaints
- Anything else as appropriate
- Patient Experience Feedback (for example compliments, complaints and PALS - where applicable)

[redacted], Consultant Speech and Language Therapist (Dysphagia and Altered Airways), leads the audit as a part of the 'Trust Safer Swallow QIP' and confirms the audit has been improved in 2025 to provide more robust quality assurance. This has included development of a quality dashboard, quarterly 'safer swallow' meetings and local audit on local usage of bed signs. The most recent audit cycle reviewed the period Jan to Aug 2025.

Safe swallowing falls within the remit of the Trust's **Nutrition and Hydration Improvement and Governance Group**. Following a review of all Trust Patient Safety Priorities (PSP) in November 2025, the Chief Medical Officer & Chief Nursing Officer have agreed that Nutrition & Hydration will remain as a Trust PSP in 2026. Leadership, membership and Terms of Reference for the Nutrition and Hydration Improvement and Governance Group have been refreshed, and [redacted] now leads the Group. The Nutrition and Hydration Group reports to the Chief Medical Officer & Chief Nursing Officer at the Group Clinical Quality Meeting.

Training of medical staff

Further, we wish to assure the court that in the intervening period since Mr Roath's admission, both senior and resident doctors have in fact received training on roles and responsibilities in relation to patients with swallowing problems including the mechanism by which to refer patients to SALT.

Specifically:

1. Between October 2024 - October 2025, 1141 doctors underwent PICS training which specifically details how to request SALT to review a patient (data provided a Digital Nurse Specialist in the UHB IT team)
2. All consultants joining UHB have undergone training on referral to SALT and Dietetics with detailed information on swallow assessment and referral. In the last 12 months, at least 83 new consultants have received this training with registers kept.
3. SALT provide annual training to the "Hospital Preparation Course IPE Lecture" (University of Birmingham (UoB)) for final year UoB medical students, last provided on June 13th 2025, which includes information on referral to SALT.

Production and distribution of a Patient Safety Notice

The inquest heard that further Trust-wide communications on SALT referrals were due to be delivered to all patient-facing staff. This communication in the form of a **Patient Safety Notice** entitled "**Inpatient referrals to the Speech and Language Therapy (SLT) team across UHB**" was distributed on 7th November 2025 via the following means, as confirmed by [redacted], Deputy Head of Clinical Governance and Patient Safety:

The safety notice has been disseminated via the following methods:

- **Intranet**:
  - Uploaded to the patient safety notice page
  - Front page of 'The Hub' ('latest news') – UHB's internal Communications platform

- **Radar notice** distributed to all ward managers and sisters, Clinical Service Leads, governance leads, Clinical Delivery Groups, and all (178) LLS Learning Ambassadors (LA's):
    - Note: Clinical Service Leads and ward managers are expected to print and post on safety boards and share with staff in handovers and huddles for a period of two week.

- **Direct email** to: Site Directors of Nursing and Clinical Governance teams

- **Onward dissemination** by others as follows:
    - Chief registrars – who send via WhatsApp groups
    - Medical and nursing education teams for inclusion in Resident Doctor newsletter
    - Inclusion in the 'Risky Practice' governance newsletter for UHB Emergency Departments
    - Library team for posting in the Libraries across site

A **Trust-wide staff notice** was also sent to all Medical, Allied Health Professionals and Nursing teams.

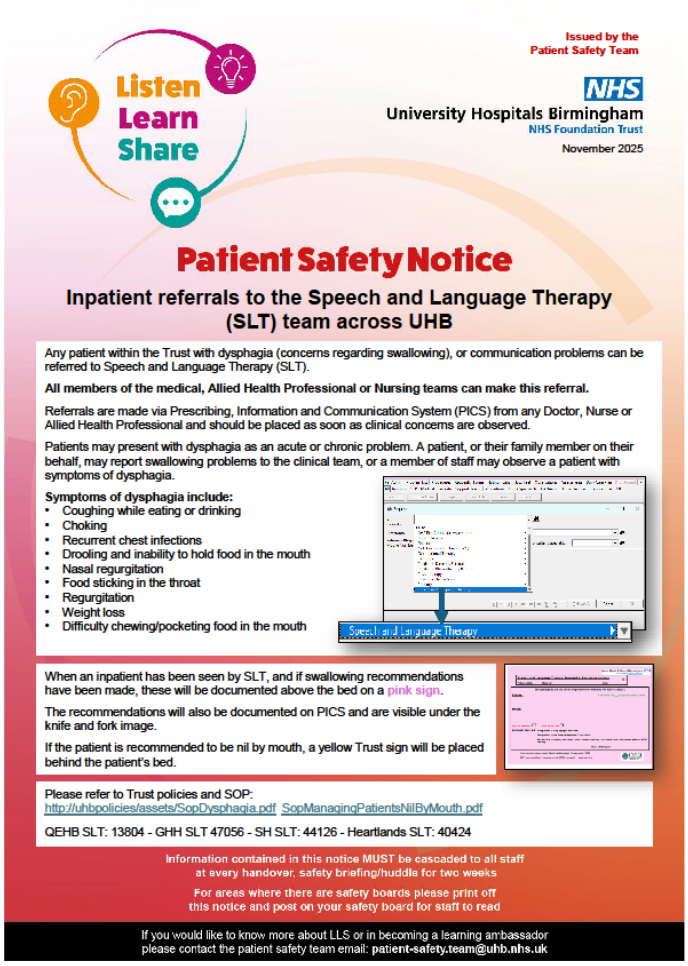
In summary, we would like to assure you that we consider the omissions in Mr Roath's care at UHB which contributed to his death, as matters of the upmost priority. In the intervening year, we have taken steps not only to improve the comprehensive training of doctors in relation to recognising and acting upon swallowing problems, but also to strengthen the wider clinical governance framework around safe swallowing.

With best wishes

[redacted]

[redacted]
Chief Executive

Enclosure:


Listen
Learn
Share
Issued by the
Patient Safety Team
NHS
University Hospitals Birmingham
NHS Foundation Trust
November 2025
Patient Safety Notice
Inpatient referrals to the Speech and Language Therapy (SLT) team across UHB
Any patient within the Trust with dysphagia (concerns regarding swallowing), or communication problems can be referred to Speech and Language Therapy (SLT).
All members of the medical, Allied Health Professional or Nursing teams can make this referral.
Referrals are made via Prescribing, Information and Communication System (PICS) from any Doctor, Nurse or Allied Health Professional and should be placed as soon as clinical concerns are observed.
Patients may present with dysphagia as an acute or chronic problem. A patient, or their family member on their behalf, may report swallowing problems to the clinical team, or a member of staff may observe a patient with symptoms of dysphagia.
Symptoms of dysphagia include:
Coughing while eating or drinking
Choking
Recurrent chest infections
Drooling and inability to hold food in the mouth
Nasal regurgitation
Food sticking in the throat
Regurgitation
Weight loss
Difficulty chewing/pocketing food in the mouth
Speech and Language Therapy
When an inpatient has been seen by SLT, and if swallowing recommendations have been made, these will be documented above the bed on a pink sign.
The recommendations will also be documented on PICS and are visible under the knife and fork image.
If the patient is recommended to be nil by mouth, a yellow Trust sign will be placed behind the patient's bed.
Please refer to Trust policies and SOP:
http://uhbpolicies/assets/SopDysphagia.pdf SopManagingPatientsNilByMouth.pdf
QEHB SLT: 13804 - GHH SLT 47056 - SH SLT: 44126 - Heartlands SLT: 40424
Information contained in this notice MUST be cascaded to all staff at every handover, safety briefing/huddle for two weeks
For areas where there are safety boards please print off this notice and post on your safety board for staff to read
If you would like to know more about LLS or in becoming a learning ambassador please contact the patient safety team email: patient-safety.team@uhb.nhs.uk