

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: [REDACTED] Chief Executive, University Hospitals Birmingham NHS Foundation Trust Trust Headquarters Level 1 Queen Elizabeth Hospital Birmingham Mindelsohn Way Edgbaston Birmingham B15 2GW.
1	CORONER I am David Donald William REID, HM Senior Coroner for Worcestershire.
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	INVESTIGATION and INQUEST On 18.12.24 I commenced an investigation and opened an inquest into the death of William Henry ROATH. The investigation concluded at the end of the inquest on 13.10.25. The conclusion of the inquest was that Mr. Roath <i>"died as the result of an accident"</i>.
4	CIRCUMSTANCES OF THE DEATH In answer to the questions "when, where and how did Mr. Roath come by his death?", I recorded as follows: <i>"On 29.10.24 William Roath, who lived with a number of significant background medical conditions, was admitted to the Queen Elizabeth Hospital, Birmingham after falling down concrete steps outside New Road Surgery, Bromsgrove. He was found to have suffered skull fractures and a traumatic brain injury which were treated conservatively, but went on to suffer a number of episodes of aspiration pneumonia. He was transferred for further rehabilitative treatment to Worcestershire Royal Hospital on 28.11.24, but while there developed another chest infection, likely the result of aspiration. He was kept comfortable, and declined and died there on 12.12.24."</i>
5	<u>CORONER'S CONCERNS</u> 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. –

	While Mr. Roath was being treated for a traumatic brain injury at the Queen Elizabeth Hospital, Birmingham, a nurse documented on 20.11.24 that he was coughing and spluttering when receiving food and documented that staff were “not to continue to feed patient”. Mr. Roath was then reviewed by a doctor that same day, who documented that there should be a SALT (Speech & Language Therapy Team) assessment, but did not record any advice about whether Mr. Roath should remain Nil by Mouth in the meantime. A referral was not made to the SALT team for another 5 days, during which time nursing staff continued to feed Mr. Roath orally. The consultant who gave evidence about the University Hospitals Birmingham NHS Foundation Trust’s (the Trust’s) own investigation into this issue told the inquest: (a) Any member of staff can make a referral to the SALT team, and in this case it should have been clearly agreed and set out who would be making the referral recommended on 20.11.24; (b) The reviewing doctor should also have documented that Mr. Roath was to be made Nil by Mouth until a further SALT assessment had been carried out; (c) Continued oral feeding between 20-25.11.24 contributed to the development/worsening of Mr. Roath’s aspiration pneumonia which was diagnosed on 21.11.24; (d) The failure promptly to assess and treat the worsening in Mr. Roath’s swallowing ability which was identified on 20.11.24 amounted to a failure to provide a basic level of care. Having heard evidence from a Senior Sister on Ward 409, where Mr. Roath was treated throughout his admission, I was satisfied that sufficient measures had been taken to try to ensure that nursing and healthcare staff did not repeat the omissions which had been identified at the inquest. When the same question was asked of the consultant in respect of doctors at the Trust, the inquest was told: <i>“a Trust-wide communication will go out to all members of staff that SALT referrals in cases of aspiration can be made by any healthcare professional, and should be made by the professional who recognizes a risk of aspiration.”</i> I am therefore concerned that, so far as doctors at the Trust are concerned, nearly 12 months after the relevant events, no action has yet been taken to try to ensure that the errors made by the doctor who reviewed Mr. Roath on 20.11.24 are not repeated.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you, as the Chief Executive of the Trust, 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 9 December 2025. 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: (a) [REDACTED] Mr. Roath’s daughter and next of kin.

	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	14 October 2025 David REID HM Senior Coroner for Worcestershire