



**York and Scarborough  
Teaching Hospitals**  
NHS Foundation Trust

[Redacted]

Medical Governance  
The York Hospital  
Wigginton Road  
YORK  
YO31 8HE

18 February 2026

Ms Gillian Kane  
Assistant Coroner for the coroner area  
of North Yorkshire & York  
Ms Gillian Kane

[Redacted]

[Redacted]

Dear Madam

Thank you for raising your concerns following the inquest surrounding the death of Mr Colin Brown and his treatment at York Hospital. We are sincerely sorry that Mr Brown died whilst in our care and offer our heartfelt condolences to his family. York & Scarborough Teaching Hospitals NHS Foundation Trust (the Trust) recognises the seriousness of your concerns outlined at Section 5 of the Report to Prevent Future Deaths (PFD) in relation to ongoing swallowing and choking risks for patients presenting to the Emergency Department. Following further review of this case I write to outline our response to your concerns.

Following this incident an immediate action was implemented ensuring that patients in the Emergency Department are not given food without the oversight of a registered nurse. This is continuing and there have been no further similar incidents.

Additional mitigations are being considered around the type of food and availability in the Emergency Department, with consideration around foods that are considered to present a higher risk of choking. Discussions are underway involving Catering Services and the Trust Food, Nutrition and Hydration Steering Group.

Where new concerns are identified about a patient's swallowing ability, the Trust has a Standard Operating Procedure (SOP) for Sip Testing in place along with training. This provides staff with guidance around how to complete a sip test to determine whether the patient is safe to eat and drink normally. If they fail the sip test e.g. due to coughing, no swallow, delayed or multiple swallows then they are referred to the Speech & Language Therapy (SALT) team for further advice and assessment to determine the most appropriate diet options for the patient.



We follow principles of safe handover practice and balance all information received with the immediate emergency needs of the patient. If we are in receipt at handover of information regarding a significant risk such as severe previous swallowing difficulties or choking risk this will be considered within the assessment of any immediate care needs to help manage the emergency situation. Action will be taken which is proportionate to the patient's clinical needs in balance with what is operationally deliverable in a busy Emergency Department. Such a significant risk would be recorded in the patient's record to ensure continuity of care throughout the patient's journey.

The introduction of the Trust's new electronic patient record (Nervecentre) is being rolled out from next month with expected completion in the autumn. This will include the option to have a prominent alert to highlight if a patient has a previously identified swallowing difficulty recorded in the system and what their recommended texture-modified diet should be. This information will therefore be clearly available at future attendances.

We hope that this information provides you with assurance that the Trust has taken your concerns on board and is working to establish improved safety in this area.

Yours faithfully

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Medical Director & Responsible Officer