Yorkshire Ambulance Service NHS Trust

06 February 2026

Ms Gillian Kane

HM Assistant Coroner for North Yorkshire and York

Springhill 2
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Dear Ma'am

Re: Inquest touching the death of Mr Colin Brown

I write on behalf of Yorkshire Ambulance Service NHS Trust (YAS) and in response to the Regulation 28 report on this matter, issued on 23 December 2025.

I am aware of the circumstances of Mr Brown's tragic death and take this opportunity to offer my sincere condolences.

I understand that this Regulation 28 report was issued in circumstances whereby YAS was not an Interested Person at the inquest, and I also note that no YAS witness was summoned to attend. Due to this, I have no knowledge of the oral evidence given but am grateful that YAS has been provided with disclosure post inquest to assist with the preparation of a response.

I am also aware that the YAS at a corporate level was not formally sighted on the Patient Safety Incident Investigation conducted by York District Hospital. This has been reviewed internally, and steps are being taken to strengthen escalation and notification routes to ensure appropriate organisational awareness and oversight in future cases.

Your matter of concern was*: "During the inquest I heard evidence that confirmed that a copy of Mr Brown's care plan was not transported with him to hospital. There was mention in the notes from Yorkshire Ambulance Service (YAS) that Mr Brown was a choking risk but there was a delay of approximately 25 minutes between Mr Brown being verbally handed across to hospital staff and the YAS Electronic Patient Form being uploaded to the Core Patient Database and accessible to staff dealing with Mr Brown. Such a delay is usual and inevitable in these circumstances, allowing time, for example, to access a device to action the upload. However, during this 25 minutes the only information that is available is what is shared orally in the handover and noted down by hospital staff. This may not include reference to a patient being a choking risk either because it is not mentioned by the ambulance crew or, because it is not deemed necessary by the hospital staff to check or to note, particularly in circumstances where this is entirely unrelated to the presenting concern. The evidence before me was that a patient being a choking risk is not routinely*

checked during all handovers. It was accepted in evidence that patients may not reliably draw attention to this crucial information themselves, as was the case here."

YAS acknowledges your concern that information relating to a patient's swallowing or choking risk documented within the electronic patient record (ePR) may not always be reliably available to receiving hospital teams at the point of initial handover, particularly where such information is not directly related to the presenting complaint and where there is an unavoidable delay before the ePR is uploaded and accessible.

We recognise that patients themselves may not always be able to reliably advocate for such risks and that reliance on verbal handover alone introduces potential variability.

To address this, I have taken advice from YAS's Associate Director of Paramedic Practice and asked that we carefully consider the matters of concern raised. I am informed as follows:

Background

"Mr Brown's conveyance was managed as a routine (non–pre-alerted) ambulance arrival for assessment of suspected acute limb ischaemia, having been assessed by the attending clinician as not requiring a pre-alert call, primarily based on the presence of pulses in the affected limb as per their documented assessment. National guidance jointly issued by the Royal College of Emergency Medicine (RCEM) and the Association of Ambulance Chief Executives (AACE) is clear that pre-alert calls should be reserved for patients where the receiving Emergency Department must prepare a different or specialised predetermined response, and that information-only (also known as "courtesy") calls should be avoided due to information overload and pre-alert fatigue.

"Accordingly, the transfer of information in this case occurred through standard structured verbal handover supported by subsequent electronic documentation (the electronic Patient Record (ePR)). Handover of non-pre-alerted patients from an ambulance crew to the Emergency Department should be completed following locally agreed processes, ideally within 15 minutes of arrival, as per NHSE's 'Guidance for emergency departments: initial assessment'.

"National NHS England guidance is explicit in defining responsibility, stating the following:

'*Responsibility for patient clinical assessment and treatment lies with the hospital from the point the ambulance arrives at the department. Ambulance clinicians need to return to their vehicle immediately after handover to prepare and make themselves available for patients needing an ambulance response in the community'*.

"The ambulance crew provided a structured verbal handover in line with national guidance, focused on the presenting complaint of suspected acute limb ischaemia, the patient's physiological status, observations, and immediate clinical risks. The paramedic described in a statement that '*we handed over his past medical history including his neurological problem, difficulty swallowing, previous skin cancer as he had a wound on his head'.*

“The information I have been provided shows the attending crew reported that Mr Brown did not disclose any requirement for a modified or soft diet to them, nor was any care plan or supporting documentation reported as existing or being provided, despite care notes within the bundle provided by HM Coroner stating Mr Brown required a modified diet. Furthermore, a collateral history was not obtainable as no carers or family members were at the scene. The ePR completed by the crew does include a past medical history entry noting previous swallowing difficulty. This reflects historical medical background obtained through them accessing the Summary Care Record for Mr Brown. This is part of routine history-taking and information gathering rather than identification of an active or clinically apparent risk at the time of ambulance assessment.

“Mr Brown was alert, orientated, speaking clearly, and was observed eating solids independently, this is information captured within the attending crew’s documentation. This is elaborated within the Patient Safety Incident Investigation (PSII) produced by York Teaching Hospitals where it states he was eating granola, not of soft consistency. This is verified in the paramedic’s statement that states “*Both of us were unaware of the fact that the patient had a soft diet. Patient when we arrived was sat eating his lunch which had yogurt and what appeared to be granola. It was definitely not a soft diet item that he was eating*”. Further to this, the PSII also describes how “*Mr Brown had the capacity to make his own decisions*.” It also states how “*he is aware of the risk of choking but often chooses to ignore this and may need reminding. Colin also refuses thickeners in his drinks*”.

“In these circumstances, it is understandable how the crew did not identify a clinical indication to specifically escalate a choking risk as part of a non-pre-alerted conveyance. The documentation of previous swallowing difficulty within the medical history section of the ePR, and the verbal handover which included this detail, as per the paramedic’s statement, represents appropriate and accurate recording of historical background information for review by the receiving department.

“Past medical history that is clinically active or presents an immediate risk would ordinarily be included within verbal handover. In this case, the patient’s Summary Care Record contained a pre-existing condition of difficulty in swallowing which was handed over both verbally and in writing. The patient did not indicate a requirement for a modified diet nor provided care plans to the crew. In these circumstances, the handover given by the crew appears appropriate and aligned to national guidance and human-factors principles.

Delay between handover and ePR upload

“YAS agrees that slight delays between verbal handover and ePR upload is inevitable given operational realities, including the need for crews to complete records safely following transfer of care and connectivity issues that can affect upload speeds. In this case, the subsequent choking event occurred approximately 90 minutes after ambulance handover and more than 50 minutes after the ePR was available to the receiving team, therefore placing it well beyond the period during which ePR upload delay would reasonably have influenced immediate clinical decision-making. In addition to the ePR,

hospitals also have access to several alternative patient care records where details indicating Mr Brown's medical history and potential choking risk may have been available. One such example is the Yorkshire and Humber Care record.

"At the time of ambulance assessment and on arrival in the Emergency Department, Mr Brown was alert, orientated, and able to speak in full sentences, with no recorded communication impairment, indicating that there was opportunity for relevant clinical history to be elicited as part of routine in-hospital assessment processes prior to decisions regarding oral intake.

Verbal handover content and process

"YAS clinicians use a structured verbal handover approach aligned to national best practice as described by AACE, RCEM and the Resuscitation Council United Kingdom (RCUK) that utilise an acronym to ensure consistency. This process prioritises pertinent clinical or background information relevant to the immediate presenting condition, physiological risk, and time-critical threats in a concise fashion. Pre-existing medical conditions such as dysphagia are pertinent and should be raised verbally as part of this process, but only where they are considered clinically active or present an immediate risk at the time of handover.

"It is not feasible, nor clinically proportionate, for ambulance clinicians to identify and verbally communicate all potential secondary risks for every patient during every handover, particularly where these are longstanding conditions documented elsewhere and unrelated to the reason for conveyance. Adopting an approach such as this increases risk of key clinical information being missed and prolongs the handover process, meaning crews will be unable to respond to further emergencies. This is reflected in national guidance and contemporary literature advocating for structured, succinct handover. Structured handover therefore represents a balance between completeness and safety, aligned with human-factors principles and the avoidance of information overload.

"For non-pre-alerted arrivals, the receiving clinician's signature on the ePR confirms acceptance of the verbal handover and formal transfer of clinical responsibility. Professional accountability requires that the written ambulance record reflects the content of the verbal handover provided at the point of transfer of care and does not materially deviate from it.

"This principle mirrors standard Emergency Department practice, for example where a verbal referral is made to a specialty team and contemporaneous written documentation is expected to accurately reflect the content of that clinical conversation. The presence of additional contextual detail within the written record does not alter the substance of the verbal handover or introduce new clinical risks that were not identified as active at the time.

"Accordingly, information documented within the ePR as historical medical background, but not escalated verbally as an active or immediate risk, should be interpreted as contextual record-keeping rather than evidence of omission from the handover process.

Swallowing risks

”YAS notes that the assessment and management of swallowing safety and dietary suitability within the Emergency Department environment sits within the receiving organisation’s clinical governance and nursing assessment processes. Decisions relating to the provision of oral intake, including solid food, are made following arrival in hospital and are informed by local risk assessment, observation and, where indicated, swallowing screening or specialist review. These processes form part of a wider system of shared safeguards designed to manage risk across the urgent and emergency care pathway.

“More broadly, national patient safety materials emphasise the risks associated with dysphagia and the need for clear, standardised approaches to food and fluid modification (including adoption of International Dysphagia Diet Standardisation Initiative (IDDSI)) terminology and avoidance of imprecise descriptors such as “soft diet”. These system safeguards sit most directly within in-hospital processes for assessing nutritional intake and swallowing safety.”

Actions to be taken to prevent future deaths

Notwithstanding the above, I accept that there is an opportunity to strengthen YAS and its partner’s practice on the communication of specific high-impact risks, such as swallowing or choking risk, where these are known and clinically relevant.

The following actions have been agreed:

1. **Clinical emphasis within handover guidance:** YAS will issue a clinical alert to all staff to reinforce that known high-risk features not directly related to the presenting complaint (for example swallowing/choking risk, severe cognitive impairment, or behavioural risk) should be considered for explicit verbal handover where omission could reasonably result in harm and that clinicians document the contents of the verbal handover.

2. **Review of handover protocols:** YAS will review its handover protocols and update where appropriate to reflect contemporary practices and learning from this tragic case.

3. **Targeted learning and awareness:** Learning from this case will be incorporated into the monthly YAS Patient Safety Bulletin accessible to all clinical staff. These materials will also support local educational sessions (termed internally as ‘investment days’) and will emphasise professional judgement, advocating for the continued use of structured, succinct and clinically pertinent handover conversations.

4. **Electronic record development (subject to system constraints)**
   YAS will explore, through its established digital governance processes, whether existing ePR systems can more rapidly share swallowing or choking risk in a consistent location, recognising that any such development is dependent on

capability, interoperability, and prioritisation alongside other patient safety requirements. This work has already begun, and YAS is exploring how pertinent clinical risks can be more accessible to receiving units.

5. **System-wide learning**
   YAS will share learning from this case through appropriate clinical forums and, where relevant, with system partners acknowledging that safe nutrition and swallowing management in Emergency Departments is a shared, multi-agency responsibility and aligned with national patient safety expectations regarding dysphagia and safe modification of food and drink.

YAS does not propose to introduce a requirement for routine verbalisation of choking risk for all patients at every handover, as adopting such an approach would not be proportionate, operationally deliverable, or aligned with human-factors principles for safe handover practice or national guidance on succinct and timely handover practice. Requiring routine verbalisation of all potential secondary issues risks information overload by the recipient and increases the likelihood that clinically pertinent details are missed.

Instead, YAS will reinforce through a targeted clinical alert that known high-impact risks, such as swallowing or choking risk, should be explicitly raised at handover where they are clinically active or present a foreseeable risk of harm. This approach supports professional judgement, maintains structured and succinct handover, and better prepares receiving teams without undermining the safety and reliability of the handover process.

I support this response to the concerns identified, which proportionately balances patient safety, professional judgement, and operational reality. I consider these actions sufficient to mitigate the specific risk identified, while remaining aligned with national best practice, human-factors principles, and the shared responsibilities across the urgent and emergency care pathway, including robust hospital-based feeding and swallowing safeguards.

My thoughts remain with Mr Brown’s family.

Yours sincerely

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Chief Executive

Cc. Senior Coroner for North Yorkshire and York