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 YAS Legal** **2 The York Hospital**
1	**CORONER** I am Gillian KANE, Assistant 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 08 April 2025 I commenced an investigation into the death of Colin Richard BROWN aged 71. The investigation concluded at the end of the inquest on 11 December 2025. The conclusion of the inquest was that: Colin Richard Brown died on the 31st of March 2025 aged 71 years. Mr Brown attended the Emergency Department at York Hospital, Wigginton Road, York on the 28th of March 2025 for assessment and whilst eating a meal, provided to him by the hospital, he had a chocking episode and required Cardiopulmonary Resuscitation. Mr Brown was moved to Intensive Care and his condition deteriorated. He died from a cardiorespiratory arrest on the 31st of March 2025. The medical cause of death was: 1a) Cardiorespiratory Arrest; 1b) Choking; 2) Traumatic Brain Injury
4	**CIRCUMSTANCES OF THE DEATH** Colin Brown had a complicated medical history including a Traumatic Brain injury in 1983. He had difficulty swallowing and was provided with a soft diet by his in-home carers to accommodate this. This information was recorded in a care plan which had been written for Mr Brown's care team to consult. Mr Brown reported feeling unwell for couple of weeks leading up to the 28th of March 2025 and carers contacted his GP who attended at his home to carry out a review. The GP arranged a health care professional admission to York Hospital Emergency Department (ED) for possible ischaemic arm due to concerns that the fingers on his left hand were blue, cold to the touch and painful. On the 28th of March 2025 then Mr Brown was taken by ambulance to York Hospital Emergency Department and a hand over from ambulance staff to hospital staff took place at 16:43hrs. At approximately 18:10hrs Mr Brown was found to be choking on food that he had been served in the ED. He had a cardiac arrest with pulse electrical activity being regained at 18:26pm and was transferred to ICU. Mr Brown received active post arrest care continuing through to early on the 31st of March 2025. It was documented that Mr Brown experienced myoclonic jerks while sedation was held and no purposeful movement, and care moved to palliative. Mr Brown died on the 31st of March 2025 at 19.38hrs.

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) 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.
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 February 17, 2026. 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] I have also sent it to **YAS Legal** **The York Hospital** 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: 23/12/2025** [redacted] **Gillian KANE** **Assistant Coroner for** **North Yorkshire and York**