REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, Sandwell and West Birmingham Hospital NHS Trust** **2. Family- Represented by Leigh Day and Co Solicitors**
1	**CORONER** I am Mr Zafar Siddique, Senior Coroner for the Black Country.
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 https://www.legislation.gov.uk/uksi/2013/1629/part/7
3	**INVESTIGATION and INQUEST** On 3 December 2024, I commenced an investigation into the death of Mrs Rashida Sultana born on the 24 April 1948 who died on the 20 November 2024. The investigation concluded at the end of the inquest on 1 October 2025. The inquest was heard before myself sitting without a Jury and my conclusion at inquest was the deceased died after choking on chips and some water she was eating and drinking. The medical cause of Mrs Sultana's death was recorded as 1a Asphyxia 1b Choking on Food II Dementia, Heart Failure, End Stage Renal Disease, Ischaemic Heart Disease
4	1. Mrs Sultana was admitted to Midland Metropolitan Hospital after presenting with symptoms of right facial drooping and slurred speech on the 18 November 2024. 2. A CT head scan confirmed she had no acute stroke but did have evidence of brain atrophy and moderate to severe small vessel disease. She also had a history of dementia, chronic kidney disease and additional comorbidities. A Do not attempt to resuscitate (DNAR) order was put into place by the Clinicians. 3. During her admission, it wasn't deemed a Speech and language therapy assessment (SALT) was required despite her risk of dysphagia from dementia and evidence of dribbling from her mouth 4. On the 20 November she choked on some chips and water the family had brought in to feed her. The nurse on duty described performing life support-administrating 5 blows to her back and using suctioning. He then contacted the on-call Doctor. 5. The on-call Doctor confirmed he wasn't told she was choking and was dealing with another emergency at the time. He was told that Mrs Sultana was struggling to breath and that he would attend as soon as he could. There was no mention of the patient becoming unresponsive.

	6. The nurse then contacted the Emergency Medical Response Team (EMRT) and when they arrived, she sadly had already passed away and nothing further could be done.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence 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. – 1. During the course of the inquest, I heard evidence Mrs Sultana was approaching end of her life and had a DNAR in place due to her multiple comorbidities. 2. My concern is that there was confusion and lack of understanding by nursing staff in relation to when the EMRT should be called in an emergency particularly when a DNAR was place. 3. In addition, there was a lack of risk assessment of when SALT assessments for those patients at risk of dysphagia should take place.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 15 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 Interested Persons [redacted] 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 other 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.
9	**Mr Zafar Siddique** **Senior Coroner** **Black Country Area** **23 October 2025**