REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

1.	**CORONER** I am Kelly DIXON, H M Assistant Coroner, for the coroner area of Staffordshire and Stoke-on-Trent.
2.	**DATE OF REPORT** 01 July 2026
3.	**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.
4.	**THIS REPORT IS BEING SENT TO** 1. University Hospitals of Derby and Burton NHS Foundation Trust 2. Staffordshire and Stoke-on-Trent Integrated Care Board You are under a duty to respond to this report within 56 days of the date of this report, namely by August 21, 2026. I, the coroner, may extend the period if an appropriate application is made.
5.	**YOUR RESPONSE** 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
6.	**SUMMARY OF CORONER'S CONCERN**

	That the Speech and Language Therapy team were unable to assess care home residents.
7.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
8.	**INVESTIGATION AND INQUEST** On 08 September 2025 I commenced an investigation into the death of Graham Keith HOLLIS aged 75. The investigation concluded at the end of the inquest on 22 June 2026. The conclusion of the inquest was that: Graham Keith Hollis, aged 75, died on 14 August 2025 at Queen's Hospital Burton after being admitted from his care home. He had recently been prescribed antibiotics on 30 July 2025 following a suspected aspiration of fluids. He was admitted to hospital after experiencing three choking episodes on 3 and 4 August 2025. Mr Hollis died from aspiration pneumonia, with dementia and frailty of old age contributing to his death. It is not possible to determine what he aspirated on.
9.	**CIRCUMSTANCES OF DEATH** Mr Hollis had significant pre-existing conditions, including dementia, and in the period before his death experienced marked weight loss, reduced mobility and increasing frailty. By late 2024 he developed coughing when drinking and was placed on a Level 4 puréed diet with thickened fluids, which was confirmed as appropriate by the Speech and Language Therapy (SALT) team during a hospital admission in February 2025. During 2025 his weight loss became more pronounced and family raised concerns that he was not tolerating the puréed diet and was refusing food. Despite attempts to obtain a further SALT assessment, this did not take place due to staffing shortages, with advice provided remotely without assessment. At a best interests meeting on 21 July 2025, it was agreed that he would be fed at risk on a supervised Level 5 minced and moist diet, with a plan to revert to Level 4 if concerns arose. Following this change, Mr Hollis initially showed improved engagement with food but remained at risk of choking and aspiration. Between 30 July and 4 August 2025 he experienced a number of coughing and choking episodes, including incidents where he was fed food inconsistent with the agreed diet and where required safeguards, including seeking medical review and reverting to Level 4, were not followed. After a further choking episode on 4 August, he was admitted to hospital and diagnosed with aspiration pneumonia. Although he received treatment, his condition deteriorated and he died on 14 August 2025. The cause of death was aspiration pneumonia, with dementia and frailty contributing; however, it was not possible to determine when, or on what, he aspirated.
10.	**CORONER'S CONCERNS** During the course of the inquest I heard evidence 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: The Speech and Language Therapy team advised the care home that, due to current staffing levels, the service was unable to undertake assessments of care homes residents, and that this issue had been escalated to the Integrated Care Board. This was the position in July 2025, and the evidence confirmed that it remained unchanged at the time of the inquest in June 2026. In the absence of a SALT face to face assessment and with no alternative provision available, a best interests meeting was convened involving the care home manager, the social worker, the GP Surgery's care coordinator, and the deceased's daughter. It was agreed that the deceased would be fed with accepted risk on a Level 5 diet without specialist assessment.
11.	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: • **Family** • **Mount Pleasant Residential Home** • **GP Surgery** • **Primary Care Network** I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
12.	**SIGNATURE**  **Kelly DIXON** **H M Assistant Coroner for** **Staffordshire and Stoke-on-Trent**