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

1.	**CORONER** I am Vanessa McKinlay, Area Coroner for Somerset.
2.	**DATE OF REPORT** 22 May 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.
3.	**THIS REPORT IS BEING SENT TO** Somerset NHS Foundation Trust You are under a duty to respond to this report within 56 days of the date of this report, namely by 17 July 2026. I, the coroner, may extend the period if an appropriate application is made.
4.	**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.
5.	**SUMMARY OF CORONER'S CONCERN** Adequacy of communication of patients' 'nil by mouth' status on transfer from the Emergency Department to a ward setting at Yeovil District Hospital
6.	**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.
7.	**INVESTIGATION AND INQUEST** On 2 September 2025, I commenced an investigation into the death of Jacqueline Marie Antoinette Frehe, aged 97 years. **The medical cause of death was:** 1a Aspiration pneumonia 1b Frailty of old age 2 Atrial fibrillation **How, when and where Mrs Frehe came by her death:** Mrs Frehe was a frail lady with a history of swallowing difficulties. On 24 August 2025 she was admitted to Yeovil District Hospital with vomiting and a productive cough. It is likely that she had aspirated vomit and secretions which led to pneumonia. On transfer from the emergency department to the ward, Mrs Frehe's nil by mouth status was not handed over. On the morning of 25 August 2025, she was given food and drink, following which she vomited. Within two hours, Mrs Frehe's condition deteriorated significantly and she died in hospital that day. **Conclusion** Natural causes to which the aspiration of vomit after eating and drinking made a contribution.
8.	**CIRCUMSTANCES OF DEATH** Mrs Frehe was assessed at the Emergency Department of Yeovil District Hospital on 24 August 2025 with dysphagia, vomiting and suspected

	aspiration pneumonia. The treatment plan was for her to remain nil by mouth, to receive intravenous fluids and antibiotics and to have a speech and language therapy assessment. On transfer to the Acute Medical Unit, her nil by mouth status was not communicated between the ED and the ward by staff. When Mrs Frehe's family mentioned her nil by mouth status, this was not documented by ward staff. Mrs Frehe was given food and drink on the morning of 25 August 2025 which led to a vomiting episode which likely contributed to her significant deterioration and death within about two hours.
9.	**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: I heard evidence from the Ward Manager. I was not satisfied that sufficient steps had been taken to ensure that: 1. patients' nil by mouth status is effectively communicated from the emergency department on transfer of patients to a ward setting; and 2. communication of a patient's nil by mouth status by family is clearly documented and communicated on the ward; and 3. ward staff question a patient's nil by mouth status on receiving a patient with a presentation of dysphagia and suspected aspiration pneumonia.
10.	**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: 1. [redacted] (the deceased's daughter) 2. NHS England 3. Secretary of State for Health and Social Care 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.

	SIGNATURE  Vanessa McKinlay Area Coroner for Somerset