TheMKWay

NHS
Milton Keynes University Hospital
NHS Foundation Trust

4 August 2025

Dear Dr Cummings,

**REF: Regulation 28 – Report to Prevent Future Deaths**

Thank you for your letter dated 18 June 2025, outlining the details of the Regulation 28 Report concerning the death of Edward Joseph Cassin, who sadly passed away while under the care of Milton Keynes University Hospital NHS Foundation Trust.

First and foremost, I would like to express my sincere condolences to Mr Cassin's family. We recognise the profound loss they have suffered, and we are truly sorry. I hope this response provides assurance that we are taking meaningful and sustained action to prevent such a tragedy from occurring again.

The findings regarding the failings in Mr Cassin's nursing care do not reflect the standard of care I expect from our nursing staff. The deficiencies identified in the management of diabetes and dysphagia are unacceptable, and we have taken steps to ensure these are not repeated.

The Regulation 28 Report outlines the following specific actions required by the Trust to prevent future deaths:

- All staff working with individuals with dysphagia must be knowledgeable about the relevant policies and procedures, particularly regarding aspiration prevention.
- Improved collaboration between clinical teams, Speech and Language Therapists (SALT), and Dietetics.

Prior to and following the conclusion of the inquest, the Trust has implemented a number of measures to ensure appropriate processes are in place for the care of patients with dysphagia. I believe these actions fulfil the requirements set out in the Regulation 28 Report and, most importantly, will ensure that patients with dysphagia receive safe, appropriate care from well-informed and trained staff.

## Management and Care of Patients with Dysphagia

The Trust is currently running a Quality Improvement Programme (QIP) focused on dysphagia management. This initiative includes collaboration between staff from both MKUH and CNWL, working together to strengthen existing practices.

The QIP has a project charter that outlines the challenges faced by the SALT and MKUH teams. The problem statement is as follows:

> ***"We are seeing a high trend in incidents where patients are choking on food or fluids. Swallow assessments are delayed, or advice is not being adequately followed, resulting in adverse incidents including aspiration pneumonia and a patient death."***

The project has three primary goals:
1. Improve the quality of SALT referrals.
2. Provide clear guidance to staff to enhance awareness and management of dysphagia prior to referral.
3. Establish clear service-level agreements and contracts.

## Actions Taken

Completed:

- Established a multi-professional group to develop a dysphagia resource pack for wards and departments.
- Redesigned and distributed the 'thickened fluids' poster in collaboration with SALT, now displayed in all inpatient clinical areas.
- Ensured all staff are familiar with the poster and understand how to identify and prepare appropriate diets.
- Introduced a new electronic SALT referral process, co-designed with CNWL, to standardise referral information and improve prioritisation.

In Progress:

- Development of an eating, drinking, and swallowing support kit (available Autumn 2025).
- Engagement of a person with dysphagia to support the QIP and training development. The Cassin family has been invited to contribute their experience to this work.
- Review of current nutritional and dysphagia training (due September 2025).
- Refinement of the audit programme to include compliance with special diets (due September 2025).
- Trial of a QR code system to inform catering of patient preferences (September 2025).
- Ongoing quality and safety walkabouts focusing on dysphagia management, involving a multidisciplinary team. All wards are expected to be visited by October 2025.

Planned:

- Development of a dedicated dysphagia policy (due August 2025).
- Implementation of patient surveys and audits to assess project impact (due September 2025).
- Design of a referral process for the Emergency Department to access SALT services (due September 2025).
- Introduction of practical training on special diet textures and preparation (commencing Autumn 2025).

Following the inquest, the Chief Nurse issued a 'call to action' email to all clinical ward leaders, reminding them of their responsibilities regarding diet and fluid management and the importance of staff training. This coincided with the release of the updated 'thickened fluids' posters.

The Trust is also investing in new bedside communication whiteboards, designed with input from SALT and Dietetics. These boards will highlight individual patient needs, including dietary requirements, and are expected to be in place by December 2025.

## Training and Education

The Trust is delivering a Fundamentals of Care training programme for all clinical staff. Each month, a different topic is covered through 7-minute learning sessions and ward-based discussions. Topics include:

- Oral hygiene
- Nutrition and hydration
- Recognition of the deteriorating patient
- Medicines safety
- Individualised personal care

The nutrition and hydration module reinforces the importance of special diets and the preparation of thickened fluids. All healthcare support workers are also required to complete the Care Certificate, which includes training on diet and nutrition.

## Improved Collaboration with SALT

Since the inquest, the Trust has worked closely with the SALT team to address the challenges of delivering care across organisational boundaries. The QIP has identified issues such as access to patient records across different systems, and efforts are underway to resolve these.

In April 2025, CNWL served notice regarding the provision of inpatient SALT services. On 9 July 2025, CNWL began a consultation process with SALT staff to transition the service in-house at MKUH. While change can be disruptive, we believe this move will improve efficiency and ultimately enhance patient care.

I trust this response provides the necessary assurance that MKUH has acknowledged and acted upon the failings identified in the Regulation 28 Report concerning Mr Cassin's death.

On a personal note, as the new Chief Nurse, I was deeply saddened by Mr Cassin's passing. I am fully committed to ensuring that incidents of this nature are not repeated, through the actions outlined above and by fostering a culture of continuous learning and improvement.

Yours sincerely,

[redacted]

[redacted]
Chief Nurse
Milton Keynes University Hospital NHS Foundation Trust