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 Milton Keynes University Hospital** **2 Central North West London NHS Foundation Trust**
1	**CORONER** I am Sean CUMMINGS, Assistant Coroner for the coroner area of Milton Keynes
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 29 June 2023 I commenced an investigation into the death of Edward Joseph CASSIN aged 66. The investigation concluded at the end of the inquest on 13 February 2025. The conclusion of the inquest was that: Narrative conclusion Eddie Cassin was a delightful elderly male with learning difficulties who was prone to silent aspiration. Although cleared for discharge home he was developing an aspiration pneumonia on the 24th June 2023 which went unrecognised. He had hypoglycaemic episodes which were not managed according to trust guidelines. He was fed jelly which was expressly contraindicated. Food and medication was left in his mouth, some of which he aspirated. This was not recognised and exacerbated the already developing aspiration pneumonia. Had he been treated for the developing aspiration pneumonia he would likely not have died at the time he did. His death was contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** Edward Joseph Cassin was an elderly man with complex medical needs and learning difficulties. He had a known dysphagia which caused him silent aspiration. He had been investigated by the Speech and Language Therapist (SALT) team and his diet was prescribed by the Dietetic Service. He had frequent chest infections/pneumonia's as a result. He was in the Milton Keynes University Hospital pending discharge to a new care home. On the 24th June 2023 he was generally out of sorts, not eating his lunch which he normally did with enthusiasm likely due to another developing aspiration infection. His diabetes had been difficult to manage and there were several alterations to his insulin regime. On the 24th June 2023 he had a hypoglycaemic episode requiring treatment. The Hospital guidelines were not followed. Because of his dysphagia he was on a modified diet and required supervision when eating to mitigate aspiration risk. Jelly was specifically and repeatedly highlighted as a food he should not be given. Despite this there was evidence of repeated administration of jelly through his stay including on the 24th June. This was a food that was specifically excluded by the Dietetic Service. Their advice was not followed. He was not properly supervised and he aspirated. The expert evidence which I accepted, was that had his developing aspiration infection been recognised and treated, he would have survived. It was made worse by the aspiration following his hypoglycaemic attack.

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) The Speech and Language Therapists (SALT) and Dietetic Service had well developed, comprehensive guidelines for investigating and managing patients prone to aspiration. Those guidelines were disseminated through the wards at Milton Keynes University Hospital and nursing and other staff were appraised of them or at least, should have been. I was disturbed to discover though that there was a lack of understanding of some of those policies and procedures some 22 months or so after the death. The SALT and Dietetic services are provided by the Central and North West London NHS Trust into the Milton Keynes University Hospital NHS Foundation Trust. It appeared to me that both Trusts were working to a degree in a siloed manner and that closer co-operation and sharing of clinical responsibility would benefit patients in a similar position in the future.
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 August 12, 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 The family of Mr Cassin 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: 18/06/2025** **Sean CUMMINGS** **Assistant Coroner for** **Milton Keynes**