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NHS
Milton Keynes
University Hospital
NHS Foundation Trust

By email

11 December 2025

Dr Sean Cummings
Assistant Coroner for Milton Keynes
[redacted]

Dear Dr Cummings

Regulation 28 Report following inquest into the death of Mr William (Billy) King

I am writing to you following receipt of the above report dated 08 October 2025. Mr King died following significant aspiration at the time of anaesthetic induction for laparotomy, conservative management for bowel obstruction having failed. Mr King had declined the placement of a Ryle's tube on admission.

You raised several concerns around:

- the adequacy of the explanation of risks to patients;
- the documentation of consent discussions;
- policy non-compliance; and,
- a lack of clarity over where responsibility sat and which professional led in relation to specific aspects of care.

Your report has led to much reflection and discussion at the Trust, including by the Executive Team and the Trust's Clinical Board (a regular meeting involving Clinical Directors, senior nurses and allied health professionals from across the organisation). We accept that we could and should have done better in explaining the risks and benefits of various treatment options to Billy such that he could have made a truly informed decision, and that there were gaps in the documentation of the same. I am very sorry that we let Billy down.

However, in the course of our discussions, we have not felt that 'consent' is the best lens through which to view this topic. Rather we feel that reinvigorating awareness, knowledge and standard operating procedures (SOPs) around 'care outside of guidance' (or 'management other than as advised by a clinician') would be a more rational and pragmatic approach. We are conscious that there are already several specific areas where care outside of guidance is well developed from both ethical and operational perspectives: namely, for women who wish to give birth without recommended obstetric or midwifery support, and for patients (including Jehovah's Witnesses) who do not wish to receive blood or blood products. Whilst documentation in these two scenarios is fairly developed, it would be timely to review this in the context of a move from paper to digital records and - in maternity specifically - the desire to facilitate patient access to the record. We have also taken the opportunity to review the Regulation 28 Report issued by HM Senior Coroner for Manchester North

on 05 November (following inquests into the deaths of Jennifer and Agnes Cahill in the context of a home birth).

We are designing a new form within our electronic patient record (eCare) which will support staff facing such situations in:

- being clear on a patient's mental capacity;
- articulating their recommended treatment along with its proposed benefits and potential risks;
- articulating alternative treatment options (including both 'do nothing' and any intervention preferred by the patient), along with an assessment of benefits (if any) and potential risks;
- reflecting upon the value of high-quality communication (including translation services and independent advocacy where appropriate), multi-disciplinary team working, and second opinions; and,
- ensuring high-quality contemporaneous documentation of valid patient decisions in such complex circumstances.

This electronic form will be generic but will prompt the user to select the specific circumstances which apply ('maternity care', 'blood products' or 'other'). In the case of maternity care and blood products, the member of staff accessing the form will be directed to scenario-specific materials and processes (e.g. policies, standard operating procedures and/or bespoke forms). Importantly, use of the form will not be mandated through policy. Rather, it will constitute an aide memoire / decision support to assist colleagues in navigating these challenging discussions with their patients. The form will be one vehicle through which to ensure appropriate documentation. Just as with consent, it is the quality, personalisation and documentation of the discussion and its conclusions – rather than specific piece of paper or electronic form – that is important. The completion of the electronic form may result – subject to further thought and design – in a 'pop up' triggered by chart opening for a specified period, alerting users to a 'care outside of guidance' discussion having been documented within a relevant timeframe.

The skeleton of the form which we plan to implement in the New Year (following feedback, revision and testing) is attached.

Yours sincerely,

[redacted]

Chief Executive Officer

Enclosed:

Enc. Proposed content for form within eCare