NHS
Medway
NHS Foundation Trust

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[redacted]

1 May 2026

Mr Ian Potter
Area Coroner
Kent and Medway Coroner's Court
Oakwood House
Oakwood Road
Maidstone
ME16 8AE

Dear Sir,

Re: Inquest touching on the death of Walter Pollyn - Prevention of Future Deaths Regulation report

We refer to your Prevention of Future Deaths (PFD) report dated 16 December 2026, which was sent to the Trust on 6 March 2026, and our response to which is due on 1 May 2026.

In advance of responding to the specific concerns raised in the PFD report, I would like to express my deep condolences to Mr. Pollyn's family. On behalf of Medway NHS Foundation Trust ('the Trust'), I want to assure the family and you that the concerns have been acknowledged, considered, and acted upon.

The Trust fully acknowledges the concerns outlined in the PFD report, especially that the incident within Mr Pollyn's care, were not merely a failure of policy adherence, but also reflected deeper behavioural, cultural, and system factors. Although relevant policies and documentation were in place at the time, they were not consistently applied in practice, leading to unsafe care and avoidable risks.

In response, the Trust has taken a whole system approach, tackling both the specific clinical issues related to 'nil by mouth' care and the underlying cultural and behavioural factors that contributed to those failures.

Addressing the immediate patient safety risks ('nil by mouth' care)

A detailed Trust-wide 'nil by mouth' care improvement action plan has been developed and implemented to directly address the potential gaps identified during the Inquest. This action plan includes:

- Trust-wide, regular 'nil by mouth' audits to evaluate adherence to best practice, including staff's ability to correctly identify 'nil by mouth' patients and the accuracy of documentation.
- Recurrent Trust-wide 'nil by mouth' audits for non-procedural patients, initially conducted on a quarterly basis while improvements are embedded. A baseline audit was completed in March 2026, with a re-audit scheduled for June 2026.

Audit findings are reviewed by the Fundamental Standards of Care Group (a Trust-wide steering and quality improvement group focused on enhancing fundamental nursing care, including nutrition and hydration, handover, mouthcare, and personal hygiene), and are escalated to the Patient Experience Sub-Committee and the Patient Safety and Harm Prevention Sub-Committee.

- Targeted education and training to enhance staff understanding of 'nil by mouth' status, supervised sips of water, and the clinical risks related to aspiration. This training is provided face-to-face alongside nutrition and hydration education, reinforced through Harm-Free Care study days, daily ward handovers, and safety huddles. Training compliance is tracked via a central training database.
- Clear visual controls and environmental safeguards, including revised bedside signage, tracking board flags, and standardised prompts, aim to reduce reliance on memory or assumptions. These include standardised bedside signage stating 'supervised water only,' removal of unsupervised water jugs, visible 'nil by mouth' indicators on electronic patient tracking boards, and clear documentation prompts. All signage and visual controls are being standardised through the Fundamental Standards of Care Group.
- Introduction of a structured 'nil by mouth' checklist for non-procedural patients to minimise practice variations and ensure key safety steps are not overlooked.
- Strengthened multidisciplinary communication to ensure all staff groups involved in bedside care, including housekeeping and support staff, are included in safety huddles and handovers.
- Digital system improvements, including exploration of automated electronic patient record (EPR) alerts to identify documentation conflicts, such as when provision of water is recorded for a patient marked as 'nil by mouth'.

Oversight of these actions is provided through established governance structures, including the Fundamentals of Care Group, Patient Experience Sub Committee, Patient Safety and Harm Prevention Sub Committee, and the Quality Assurance Committee. These bodies operate with defined review cycles (detailed in Group Terms of Reference) to ensure sustainable improvement rather than relying on one-off compliance activities.

Addressing behavioural and cultural contributors

Crucially, the Trust has recognised that the issues highlighted in this PFD report go beyond processes and include normalised behaviours, such as task-driven 'box ticking', and reliance on routine practice rather than individualised risk assessment.

To address this, the Trust has integrated the 'nil by mouth' improvement work into its Cultural Transformation Programme, a multi-year Board-led initiative aimed at addressing the behavioural, leadership, and attitudinal factors that impact patient and staff safety.

Phase 1 of the Cultural Transformation Programme (completed in September 2025) involved extensive listening sessions (events where staff can share their views, wishes, and feedback based on their experience), workforce surveys, and a Board cultural competence review. This work identified consistent themes including:

- Inconsistent application of policy in practice
- Reduced challenge and escalation in pressured environments

- Normalisation of unsafe workarounds
- Fear of speaking up
- Variable leadership visibility and accountability.

Some of these themes are directly related to the issues uncovered in Mr Pollyn's case.

These insights have informed a series of high-impact actions already in progress, including:

- Stronger leadership accountability frameworks that explicitly connect behaviours to appraisal, recognition, and consequences.
- Board-level oversight of culture and safety, with regular progress review integrated into formal governance.
- Improved psychological safety and speaking up initiatives, ensuring staff feel able to challenge unsafe practice without fear.
- Targeted development for middle and senior leaders, recognising their critical role in setting behavioural norms at ward level.
- Clear reinforcement that patient safety outcomes — not task completion — define success.

Assurance of sustainability

The Trust is clear that reassurance cannot be given through policies or training alone. Therefore, improvements are being integrated through:

- Recurrent audit and measurement
- Visible leadership ownership
- Integration into existing safety and quality governance
- Cultural metrics alongside clinical performance data
- Ongoing monitoring through Patient Safety and Harm Prevention Sub-Committee and Board reporting.

The Trust is committed to ensuring that the lessons learned from this case lead to lasting improvements in how patients at high risk of aspiration are identified, protected, and cared for — and in how staff are supported, while complacency is challenged and addressed.

Summary

The Trust accepts that Mr Pollyn's death highlighted unacceptable gaps in practice and culture. Significant measures have been taken, and are ongoing, to address both the specific clinical risks identified by the Coroner and the wider cultural factors that allowed these risks to persist. On behalf of the Trust, I am confident that these combined measures materially reduce the likelihood of a similar death occurring in the future, and the organisation remains committed to continuous oversight, learning, and improvement.

We thank the learned Coroner for raising this matter with us and for highlighting an opportunity to improve our process.

Yours sincerely,

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[redacted]

Deputy Chief Medical Officer
Medway NHS Foundation Trust