Kent and Medway Coroners' Service
Oakwood House
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Kent
ME16 8AE
[redacted]

Date: 16 December 2025
[redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: The Chief Executive, Medway NHS Foundation Trust

1. CORONER

I am Mr. Ian Potter, Area Coroner for Kent and Medway

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.

http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7

http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

3. INVESTIGATION and INQUEST

On 3 September 2024 an investigation was commenced into the death of Walter Perekuno POLLYN, aged 67 years at the time of his death on 16 August 2024. The investigation concluded at the end of the inquest, heard by me on 16 December 2025. The conclusion of the inquest was

Natural causes

1a Pneumonia

1b Polymyositis

1c

1d

II

4. CIRCUMSTANCES OF THE DEATH

Walter Pollyn was admitted to Medway Maritime Hospital on 19 July 2024 following an

unwitnessed fall and increased confusion. On admission, he tested positive for Covid-19 and was placed on oxygen therapy due to respiratory complications.

Following a Speech and Language Therapy (SALT) assessment, Mr Pollyn was made 'nil by mouth' (NBM) due to oropharyngeal dysphagia. The advice of the SALT team was not followed and water was repeatedly left within Mr Pollyn's reach. On 24 July 2024, Mr Pollyn drank half a glass of water, despite being NBM. Mr Pollyn aspirated the water which did not assist his overall condition. On the afternoon of 24 July 2024, Mr Pollyn's condition deteriorated further and he was intubated following his transfer to ITU.

On 14 August 2024, following discussions with Mr Pollyn's family, he was place on an end of life care pathway. Sadly, Mr Pollyn in hospital on 16 August 2024.

The immediate cause of Mr Pollyn's death was pneumonia, which was multifactorial. Those factors included aspiration pneumonia. It is not possible to quantify to what extent each factor contributed to Mr Pollyn's death. Nonetheless, Mr Pollyn should not have been in the situation (on 24 July 2024) where he was able to consume half a glass of water unsupervised, which was not in line with the Trust's policy.

5. CORONER'S CONCERNS

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

I wish to acknowledge that the Trust's After Action Review (AAR) highlighted a number of matters and there was evidence at the inquest that the Trust has addressed some of those matters.

The **MATTERS OF CONCERN** are as follows. -

(1) Having been made 'nil by mouth', the evidence was that this was well documented in Mr Pollyn's records, a sign indicating that he was nil by mouth was placed above his bed, and the board within the ward kitchen was also updated. Despite this, the records indicate that numerous members of nursing staff ensured that water was placed at Mr Pollyn's bedside (which would be standard practice were Mr Pollyn not 'nil by mouth' at the time). While the Trust has updated the relevant policies and sought to disseminate messaging to staff in this regard, I was not reassured that this is solely a matter of policy. The number of staff involved and the period of time over which the issue of unsupervised access to water persisted is potentially suggestive of underlying attitudinal issues.

(2) Following on from the above, I heard in evidence that the production of some patient records is a simple tick-box exercise, which is not a concern in itself. However, the impression created by the evidence was that staff members were ticking the box to indicate that water was placed/replaced at the bedside (and following through on that action) because that was the norm for most patients on the ward. This indicates that staff missed the entries in the notes about 'nil by mouth' and the other visual cues that were clear. While I heard that the Trust intends to undertake a review of record keeping, which may not be completed until March 2026, I was given insufficient reassurance that this specific concern is being addressed.

6. ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you 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 1st May 2026. 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: Mr Pollyn's family.

I am also under a duty to send the Chief Coroner a copy of your response.

The Chief Coroner may publish either or both in a complete or redacted or summary form. She may send a copy of this report to any person who she 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.

16 December 2025

Signature 

Ian Potter, Area Coroner for Kent and Medway