NHS
Somerset
NHS Foundation Trust

Trust Management Headquarters
Yeovil District Hospital
Higher Kingston
Yeovil
BA21 4AT

[redacted]

24th June 2026

Dear Mrs McKinley,

Re: Regulation 28 Report – Prevention of Future Deaths: Mrs Jacqueline Frehe

Thank you for your correspondence dated 22 May 2026 regarding your Regulation 28 Report issued following the inquest into the death of Mrs Jacqueline Frehe, which concluded on 21 May 2026.

First and foremost, I would like to extend my sincere condolences to Mrs Frehe's family. We have carefully considered the findings of the inquest and fully recognise the importance of addressing the concerns you have raised to reduce the risk of similar incidents occurring in the future.

Your report identified three key areas of concern:

Communication of nil by mouth (NBM) status during transfer from the Emergency Department to inpatient wards

Documentation and escalation of NBM status communicated by family members

The clinical verification and challenge of NBM status in patients presenting with dysphagia and suspected aspiration

In response, the Trust has developed a comprehensive programme of work to address each of these areas.

1. **Standardisation of Emergency Department to Ward Handover**

We have initiated a Trust-wide Quality Improvement programme focused on strengthening the handover process between the Emergency Department and receiving areas. This work includes the development of a revised SBAR-based handover template (standardised

communication framework [Situation, Background, Assessment, Recommendation]) with clearly defined mandatory fields, including dietary status, where NBM will be identified as a critical safety parameter.

In addition, we plan to embed a ‘safety pause’ within the transfer process, requiring both transferring and receiving staff to confirm key patient risks, including NBM status, before handover is completed. This will be supported by clearer accountability, including named individuals responsible for providing and receiving handover information.

This programme also includes a review of our standard operating procedures for patient transfers to ensure that appropriate staffing, equipment, and communication processes are consistently in place.

The Trust has strengthened its approach to incidents involving communication/ sharing of patient information, and handover by undertaking **After Action Reviews (AARs)** in accordance with the principles of Patient Safety Incident Response Framework (**PSIRF)**. This approach supports the rapid identification of learning, promotes a systems-based understanding of the factors influencing practice, and enables proportionate improvement actions to be implemented at the point of care. Learning derived from AARs is also aggregated and considered within wider Quality Improvement workstreams, ensuring that themes relating to information sharing and ward-level handover arrangements inform our longer-term organisational improvement and risk reduction strategies This work is being done in conjunction with our Patient Safety Faculty.

To date we have completed 2 after action review events which whilst they relate to differing care episodes we recognise there is transferable learning that needs to be combined and considered.

The After Action Review identified that the primary contributory factors related to information sharing, communication and system design rather than individual staff actions..

The review identified weaknesses in the communication of critical safety information during ward transfer and handover processes, with no structured mechanism to highlight essential swallowing restrictions.

The review further identified opportunities to strengthen the systems supporting safe care, including the need for more effective integration of bedside safety information into routine workflows, improved prompts to review specialist guidance, and greater visibility of dysphagia-related risks. Learning highlighted that reliance on documentation and posters alone may not be sufficient to ensure compliance with specialist feeding plans, particularly during periods of ward transfer, high patient turnover or increased operational pressure.

As a result, immediate actions included reinforcing Speech and Language Therapy recommendations with ward staff, providing additional education regarding dysphagia risks and sharing the learning through ward safety huddles and wider service-level communications. The identified learning will also inform ongoing Quality Improvement work focused on strengthening handover processes, communication of clinical risk information and the reliability of safety-critical information transfer across care settings.

2. Documentation and Escalation of Information from Families and Carers

We acknowledge the concern that information provided by Mrs Frehe's family regarding her NBM status was not fully recognised or acted upon. We recognise the vital contribution that families and carers make in identifying risks and supporting safe, person-centred care.

To address this, we are strengthening expectations for staff to clearly document, escalate, and act upon concerns raised by families. This will include:

- Recording family concerns within the transfer process - utilising family conversations into the relevant background section of the handover model.
- Reinforcing the requirement for escalation and clinical review
- Introducing closed-loop communication to confirm key risks such as NBM status between clinicians. This would involve nurse to nurse/AHP and or nurse to medic using a closed loop handover. This would involve using our existing SBAR handover tool but asking or seeking the recipient of the information to confirm the information has been heard, understood and acted on. The risk, control measures and escalation plan have all been verified in the conversation. At the bedside this will involve nursing teams asking or reviewing what is the risk for this patient, what are we doing about it? And what will trigger escalation? If these elements are handed over and confirmed back, the team will have achieved a meaningful closed loop communication.

These measures will be supported by visible bedside alerts and reinforced through daily safety huddles to ensure a consistent, shared understanding amongst all members of the care team.

3. Clinical Education and Competency

We are continuing to strengthen education and training for clinical staff in relation to dysphagia, aspiration risk, and safe management of nutrition and hydration. This includes targeted ward-based teaching and promotion of the International Dysphagia Diet Standardisation Initiative (IDDSI) e-learning programme, delivered in collaboration with our speech and language therapy colleagues. We would aim to have 90% of staff within the service group trained within the next 6 months. Our clinical skills facilitators are promoting this training alongside delivery of their snack box training in conjunction with our hydration and nutrition team.

This training focuses on improving staff understanding of safe swallowing, appropriate dietary modifications, escalation processes, and interim safety measures while awaiting specialist assessment.

Training compliance and impact will be monitored through established governance mechanisms, including the PSIRF and review of incident data. Hydration and nutrition remain a key local priority within this framework.

4. Visual Identification and Safety Communication

We have identified the need to improve the visibility of NBM status across all clinical settings. As part of our improvement work, we are reviewing how patient safety information is communicated both during transfers and within ward environments. Currently information about a patient such as nil by mouth status will be written behind the bedspace utilising the

patient glance board. This is updated using a whiteboard pen. This safety critical information should also be considered at the ward daily safety huddle so that all ward team members are aware.

This includes work to:

- Standardise bedside information and safety alerts
- Improve the consistency of safety huddles, briefings, and handovers
- Develop a Trust-wide handover framework that supports clear, concise communication of key patient safety risks, including NBM status

This will ensure that critical information is consistently visible, up to date, and understood by all members of the multidisciplinary team.

Governance, Oversight and Assurance

All actions arising from this work will be captured within a structured and tracked action plan. Progress will be monitored through the Trust's governance framework, including the Patient Safety Incident Response Framework and Ward Accreditation Programme.

This will enable triangulation of audit findings, incident trends, patient experience, and learning to ensure that improvements are effectively implemented, embedded, and sustained across the organisation.

We fully recognise the seriousness of the concerns raised and are committed to ensuring that robust systems are in place to support safe communication and care delivery for patients at risk of aspiration. We are confident that the actions outlined above will deliver meaningful and measurable improvements to patient safety.

I hope this response addresses the concerns raised in your Regulation 28 Report.

Please do not hesitate to contact me if you require any further information.

Yours sincerely

Chief Executive