North East Kent Coroners
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For the attention of:

East Kent University Hospitals Foundation Trust

The Manor Clinic Folkestone Kent

Regulation 28: Report to Prevent Future Deaths

1. CORONER

I am Sarah Clarke, Area Coroner for North East Kent.

2. CORONER'S LEGAL DUTY

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

An inquest into the death of Mrs Ann Caldicott, aged 66, was opened on 8th July 2024 and concluded on the 7th April 2025.
The medical cause of death was:
- 1a. Septic Shock
- 1b. Generalised Peritonitis
- 1c. Iatrogenic Bladder Perforation
- II. Congestive Heart Failure, Ischaemic Heart Disease, Hypertensive Heart Disease, Generalised Atherosclerosis, Type 2 Diabetes Mellitus, Atrial Fibrillation, Acute on Chronic Kidney Disease

The conclusion of the inquest was a Narrative Conclusion as follows:

"Mrs Ann Caldicott was admitted to hospital on the 17th January 2024 having been unwell for some time with lack of appetite, weight loss and dehydration amongst other symptoms. She had become increasingly frail despite numerous interactions with both primary and secondary care.

On her final admission Mrs Caldicott underwent investigations including a kidney biopsy complicated by bleeding and she was found to have a perforated bladder caused by the insertion of a urinary catheter. Mrs Caldicott was considered too physiologically frail to undergo the treatment required to fix the perforated bladder and Mrs Caldicott died in hospital on the 21st February 202"

4. CIRCUMSTANCES OF THE DEATH

Mrs Caldicott had a long-standing history of weight loss, anaemia, and deterioration in renal function. Despite multiple attendances and admissions to both primary and secondary care, no adequate nutritional assessment, referral to specialist services, or frailty intervention occurred. These failures contributed to a profound physiological decline. On her final admission, a urinary catheter insertion resulted in a bladder perforation. Due to her poor physiological reserve, she was deemed unfit for the necessary surgical intervention and died in hospital on 21 February 2024.

5. 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 could occur unless action is taken.

The matters of concern are as follows:

1. Ann's malnutrition and declining frailty were not investigated despite continued requests by Ann and her family to primary and secondary care settings.
2. Ann's marked Anemia and poor nutritional state meant that she was not suitable for potentially lifesaving treatment when it became necessary.
3. No internal investigations were conducted by Ann's GP or by the East Kent Hospitals NHS Foundation Trust to establish if lessons could be learned as a result of the circumstances of Ann's Death.
4. The Court was informed that there had been an SJR (of which I had not previously been notified) following Ann's death. The Dr providing evidence was to raise a Datix in relation to Ann's previous attendances and failed discharges. At the resumed inquest the Court were informed these investigations had not taken place and were not to take place.
5. No consideration was given prior to Ann's final admission and some 18 months after the onset of symptoms of vomiting and chronic weightless, of support for Ann's nutritional status.
6. If Ann had been in a better nutritional state on her final admission to the Kent and Canterbury, then she would have been well enough to undergo lifesaving treatment following the bladder perforation.

6. ACTION SHOULD BE TAKEN

In my opinion, action should be taken to prevent future deaths, and I believe that your organisation has 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 4th August 2025.

I, the Coroner, may extend this period if necessary.

Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. If no action is proposed, you must explain why.

8. COPIES AND PUBLICATION

I have sent a copy of this report to:
- The Chief Coroner
- The family of Mrs Ann Caldicott
- East Kent Hospitals University NHS Foundation Trust

- The Manor Clinic

I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who received the report.

The Chief Coroner may publish either or both this report and your response on the Judiciary website.

9. DATE

07 June 2025

10. SIGNED

Sarah Clarke
Area Coroner for North East Kent