[redacted] **Chief Executive**
University Hospitals Plymouth NHS Trust
Plymouth PL6 8DH
Tel. 01752 439084

Private and Confidential

09 February 2026

Ms Louise Wiltshire
Assistant Coroner, for the coroner area of the County of Devon, Plymouth and Torbay
County Hall
Topsham Road
Exeter
EX2 4QD

[redacted]

Dear Ms Wiltshire,

I am writing in response to your Regulation 28 Report dated the 15th of December 2025 concerning the death of Mr Eustace. On behalf of University Hospitals Plymouth NHS Trust (UHP), we would like to begin by offering our sincere and heartfelt condolences to Mr Eustace's family for their profound loss.

Thank you for clearly setting out the concerns arising from this case. We are sorry that these matters required your intervention, and we recognise the seriousness of the issues you have raised. We are committed to learning from this incident and taking all necessary steps to strengthen the safety and quality of our services to prevent future harm.

During the inquest, the following matters of concern were identified:

1. The jejunostomy feeding protocol in place at the time of Mr Eustace's death was insufficient and not followed. This likely contributed, on the balance of probability, to his death.
2. Despite these concerns, an incident was not reported through the Trust's internal incident reporting system, a proportionate investigation did not take place, and Duty of Candour was not provided to Mr Eustace's family.
3. There was a failure to disclose these concerns and any associated service improvements to the coroner ahead of the inquest hearing (which was subsequently adjourned) in June 2023.

A full investigation into each of these issues has now been completed, and our response is set out below.

1. ***The jejunostomy feeding protocol in place at the time of Mr Eustace's death was insufficient and not followed. This likely contributed, on the balance of probability, to his death.***

   Mr Eustace was admitted under the care of the Thoracic team on the 27th of April 2022 for an upper gastrointestinal endoscopy and two stage Gastro-Oesophagectomy for squamous cell

carcinoma of the oesophagus. Postoperatively, and in line with established practice within the Thoracic Service Line, he was commenced on jejunostomy feeding at 30ml/hr.

Mr Eustace subsequently developed abdominal pain. Although the feeding protocol in place at that time indicated that feed should not be increased when abdominal pain is present, the rate was increased. Over the following 24 hours, Mr Eustace's abdominal pain and distension worsened, his tachycardia increased, his urine output decreased, and he appeared more unwell.

In the absence of the operating consultant, Mr Eustace was reviewed by a consultant from the Oesophagogastric team. The reviewing consultant raised concern for feeding jejunostomy syndrome, which is a rare situation, peculiar to patients post upper gastrointestinal surgery, where the jejunal feed inspissates in the bowel and causes bowel ischaemia. A CT scan was performed which confirmed an ischaemic bowel. Sadly, the extent of ischaemia meant that surgery was not an option. Supportive care was provided with input from the Intensive Care team, but Mr Eustace's condition did not improve, and he died on the 1st of May 2022.

The investigation identified that at the time of Mr Eustace's death there was variation in post-operative pathways for patients undergoing a Gastro-Oesophagectomy between the Thoracic and Oesophagogastric teams, including differing approaches to jejunostomy feeding. Although jejunostomy feeding post-surgery had been used for many years within the Thoracic Service Line, feeding jejunostomy syndrome had not previously been encountered and was not widely recognised by staff as a potential complication. The protocol in place did prompt staff to consider abdominal pain. However, it did not clearly explain the clinical significance of this finding, how to distinguish expected postoperative discomfort from red-flag symptoms, or the actions required if abdominal pain or other concerning symptoms were identified.

Following Mr Eustace's death, the jejunostomy feeding protocol (Appendix 1) was revised in September 2022. It now includes a daily checklist with explicit instructions regarding abdominal pain and other clinical warning signs. In addition, the pathway for all Gastro-Oesophagectomy patients at UHP has since been standardised and feeding jejunostomies are no longer used post-operatively. This change has removed the risk of feeding jejunostomy syndrome entirely for this patient group.

2. ***Despite these concerns, an incident was not reported through the Trust's internal incident reporting system, a proportionate investigation did not take place, and Duty of Candour was not provided to Mr Eustace's family.***

Feeding jejunostomy syndrome is a rare but known complication that is poorly understood. However, the Trust acknowledges that an incident did occur during Mr Eustace's admission which met the threshold of a notifiable patient safety incident. This should have triggered an incident report, a proportionate investigation, and the provision of both professional and statutory Duty of Candour to Mr Eustace's family. The incident relates to the decision to continue and increase the feed in the presence of abdominal pain, which likely contributed to Mr Eustace's death.

I am sincerely sorry that this did not happen at the time, and that Mr Eustace's family did not receive the openness, involvement, and information they were entitled to until the inquest in December 2025.

The investigation could not establish with certainty why an incident report was not raised, but it is possible that staff did not recognise that a patient safety incident had occurred at the time of Mr Eustace's death. In addition, although all deaths within UHP should undergo review, there is no

evidence that Mr Eustace's death was reviewed or considered at the Thoracic Surgery Morbidity and Mortality meeting. As a result, these processes did not identify the incident, the need for it to be reported, or the requirement to provide Duty of Candour to Mr Eustace's family.

Recognition of the incident occurred only later, when an independent clinician from the Oesophagogastric team, who had reviewed Mr Eustace when he became acutely unwell, was asked to provide an opinion for the previously adjourned inquest.

3. ***There was a failure to disclose these concerns and any associated service improvements to the coroner ahead of the inquest hearing (which was subsequently adjourned) in June 2023.***

   Since Mr Eustace's death, improvements have been made to UHP's learning from deaths and mortality review processes to strengthen the early identification of concerns in care that may have contributed to a patient's death. These include:

   - All coroner referrals are now reviewed by the Divisional Quality Team to ensure any concerns in care are identified at an early stage.
   - All adult deaths within surgical services at UHP now undergo a Stage 1 mortality screening review, using a standardised tool.
   - If any triggers are identified, a Structured Judgement Review (SJR) is undertaken by an independent clinician.
   - Any concerns identified through these processes are reported through the Trust's incident reporting system, ensuring duty of candour is provided, and appropriate investigation and learning.

   Copies of the Stage 1 screening tool and the SJR template are included at Appendix 2.

The Trust apologises that these concerns were not identified and addressed prior to the inquest held in June 2023 and again in December 2025 and hopes that this response provides some reassurance that we have fully explored the concerns raised, and that we are committed to taking the necessary steps to improve the safety of our services.

If you require any further information or clarification, please do not hesitate to contact me. Once again, we extend our deepest condolences to Mr Eustace's family for their loss.

Yours sincerely

[redacted]

[redacted]
Chief Executive Officer

Appendix 1 – Adult Jejunostomy Feeding

Plymouth Hospitals NHS
NHS Trust

Department of Nutrition & Dietetics
Office hours
Monday to Friday 8.30-4.30pm

Adult Jejunostomy Feeding Regime

Dietitian Name _____ **Date:** _____ **Contact No: 32243** **Bleep:** _____	**Surname:** **First Name:** **Hospital Number:** **NHS Number:** **DOB:** *Affix patient label here*

This regime is intended for patients commencing jejunostomy feeding following surgical placement of a jejunal feeding tube. Following tube insertion:

- Refer to dietitian via SALUS as soon as possible for formal nutritional assessment to establish feed and target feeding rate
- **DAILY:** Flush 50mls sterile water every 4 hours, after each feed and after any medication.
- To prevent dehydration IV fluids should be given until adequate fluid is tolerated via the jejunostomy tube.

1. Keep patient **NIL BY TUBE** for **12 hours** after insertion of jejunostomy tube, except for flushes			
2. Feed: Sterile water	**SET RATE:** 30mls/hr	**SET DOSE:** 180mls	**TIME:** 6 hours
3. Feed: Osmolite	**SET RATE:** 30mls/hr	**SET DOSE:** 720mls	**TIME:** 24 hours
Has the patient passed flatus?	**NO:** Maintain Step 3 **YES:** Progress to Step 4		
4. Feed: Osmolite	**SET RATE:** 45mls/hr	**SET DOSE:** 1080mls	**TIME:** 24 hours
Has the patient opened their bowels?	**NO:** Maintain Step 4 and consider Laxido **YES:** Progress to Step 5		
5. Feed: Osmolite Continue until dietitian review below:	**SET RATE:** 60mls/hr	**SET DOSE:** 1440mls	**TIME:** 24 hours

Dietitian Use

Continue to increase the feeding rate by 15ml/hr every 8 hours until the target rate of ___mls/hr is established.

Feed Name:			
Target Rate (mls/hr):			
Duration (hrs):			
Flushes (if different from below)			
Feed Content:	**Energy** _____ **kcals**	**Protein** ____ **g**	**Fluid** _____ **mls**

Daily Checklist:
Has the patient got any of the following?
- A painful distended abdomen
- Nausea
- High NG Output

STOP FEED and liaise with dietitian /surgical team. If this coincides with high WBC & CRP +/- hypotension then may need a CT to rule out bowel necrosis

- Flush jejunostomy tube with 50mls sterile water using a 60ml enteral syringe (purple) after each feed and before and after any medication (**Minimum 6 flushes per day**). If feeding is discontinued flush the tube at least once daily.
- **Check with your ward pharmacist that all medications are suitable to be given into the jejunum. Change all medications to soluble or linctus forms if possible to prevent tube blockage.**
- Giving sets must be changed daily. Label new set with date and time.
- Document all feeds and flushes on fluid balance chart.

To be filed in the Nursing Notes

Adult Jejunostomy Feeding Regime/Updated Sept 2022 HRSG Issue: 0243/2 RE-ORDER MEDPHOTO 109316 N826

Appendix 2 - Mortality Screening Tool

NHS University Hospitals Plymouth NHS Trust

Stage 1 - Mortality Review Screening Tool

Stage 1 mortality review form and screening tool			
Patient Name			
Hospital number			
Date of admission			
Date of death			
Consultant (Responsible for care)			
Service Line (at time of death)			
Screening completed by			
Cause of death *(as recorded on the Death Certificate if available)*			
1 a			
1 b			
1 c			
2			
Coroner involvement		Yes	No
Was this death reported to the coroner?		☐	☐
Criteria for stage 2 structured judgement case note review (SJR)		Yes	No
Do you believe the death was unexpected?		☐	☐
If the patient death was expected was there an absence of end of life care planning or DNACPR form?		☐	☐
Has an incident been raised in relation to this patient's death? (if a serious incident investigation is ongoing an SJR is not required)		☐	☐
Was the patient admitted for an elective procedure?		☐	☐
Did the patient have a learning disability or a severe mental illness?		☐	☐
Has a safeguarding concern been raised?		☐	☐
Have staff or the bereaved family raised concerns about care ?		☐	☐
Criteria for structured judgement case note review (SJR)		Yes	No
For a stage 2 Structured judgement case note review (SJR)? (If yes to any of the above then a review is required) You may wish to put this forward for an SJR for another reason, if so please document rational here:		☐	☐
If a structured judgement case note review (SJR) is not required are there any aspects of excellent care that you wish to highlight?			
Any further comments to aid senior review?			

Stage 2 structured judgement case note review (SJR)	
Patient Name	
Hospital number	
Service Line	
Review completed by	
Date	

Phase of care: Admission and initial management (approximately the first 24 hours) - *Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.*

Please rate the care received by the patient during this phase.

1. **Very Poor Care** ☐
2. **Poor Care** ☐
3. **Adequate Care** ☐
4. **Good Care** ☐
5. **Excellent Care** ☐

Phase of care: Ongoing care - *Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.*

Please rate the care received by the patient during this phase.

1. **Very Poor Care** ☐
2. **Poor Care** ☐
3. **Adequate Care** ☐
4. **Good Care** ☐
5. **Excellent Care** ☐

Phase of care: Perioperative care

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1. **Very Poor Care** ☐
2. **Poor Care** ☐
3. **Adequate Care** ☐
4. **Good Care** ☐
5. **Excellent Care** ☐

Phase of care: End-of-life care

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1. **Very Poor Care** ☐
2. **Poor Care** ☐
3. **Adequate Care** ☐
4. **Good Care** ☐
5. **Excellent Care** ☐

Overall assessment

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1. **Very Poor Care** ☐
2. **Poor Care** ☐
3. **Adequate Care** ☐
4. **Good Care** ☐
5. **Excellent Care** ☐

Assessment of problems in healthcare

In this section, please comment on whether one or more specific types of problem(s) were identified and, if so, to indicate whether any led to harm.

	Yes	No
1. **Were there any problems with the care of the patient?** (If you did identify problems, please identify which problem type(s) from the selection below)	☐	☐
a. **Problem in assessment, investigation, or diagnosis** (including assessment of pressure ulcer risk, venous thromboembolism (VTE) risk, history of falls)	☐	☐
b. **Problem with medication / IV fluids / electrolytes / oxygen** (other than anaesthetic)	☐	☐
c. **Problem related to treatment and management plan** (including prevention of pressure ulcers, falls, VTE)	☐	☐
d. **Problem with infection management**	☐	☐
e. **Problem related to operation / invasive procedure** (other than infection control)	☐	☐
f. **Problem in clinical monitoring** (including failure to plan, to undertake, or to recognise and respond to changes)	☐	☐
g. **Problem in resuscitation following a cardiac or respiratory arrest** (including cardiopulmonary resuscitation (CPR))	☐	☐
h. **Problem of any other type not fitting the categories above** (including communication and organisational issues). If yes please specify below:	☐	☐
Other comments:		