ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. University Hospitals Plymouth NHS Trust**
1	**CORONER** I am Louise Wiltshire, Assistant Coroner, for the coroner area of the County of Devon, Plymouth and Torbay
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.
3	**INVESTIGATION and INQUEST** On 23 May 2022 an investigation was commenced into the death of Lee Kenneth EUSTACE. The investigation concluded at the end of the inquest on 12 December 2025. The narrative conclusion of the inquest was as follows: Lee Kenneth Eustace died on 1 May 2022 from a rare but recognised complication of jejunostomy feeding; jejunostomy feeding syndrome. There were multiple opportunities to recognise that Lee was suffering from this rare complication, and opportunity to provide effective treatment. Unfortunately these were missed and Lee developed an ischemic bowel, the extent of which by the time it was recognised was not reversible. The medical cause of death was: 1a Bowel ischaemia 1b Jejunostomy feeding syndrome 1c II Oesophageal cancer, hypertensive heart disease

4	**CIRCUMSTANCES OF THE DEATH** Lee Eustace was admitted to hospital on 27 April 2022 for an upper GI endoscopy and stage 2 gastro-esophagectomy as part of his treatment for squamous cell carcinoma of the oesophagus. In accordance with usual practice Lee was commenced on a jejunostomy feed at 30ml/hr at 1300 on 28 April 2022. There was a Trust protocol in place at the time which indicated when to increase the jejunostomy feed, but did not set out the risks of jejunostomy feeding, when to stop it, or when to seek senior review. At some point between 13:00 and 21:15 on 28 April 2022 Lee started to complain of abdominal pain. Despite indication on the protocol that the feed should not be increased if the patient complains of abdominal pain, the feed was increased to 45ml/hr at 21:15 on 28 April 2022. Evidence heard at the inquest confirmed that the feed should have been stopped at 21:15 and that jejunostomy feeding syndrome should have been considered. The feed continued and Lee continued to complain of pain. There were numerous opportunities on 29 April 2022 to recognise that Lee was suffering from the very rare complication of jejunostomy feeding syndrome and the feed to have been stopped. The treatment for jejunostomy feeding syndrome is stopping the feed. Had the feed been stopped on 28 or 29 April 2022, on balance of probabilities, Lee would not have gone on to develop such significant bowel ischaemia and would not have died when he did. Lee died in ICU at Derriford Hospital on 1 May 2022.
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. The **MATTERS OF CONCERN** are as follows. – During the inquest I heard evidence that the jejunostomy feeding protocol in place at the time of Lee's admission was insufficient and, in part not followed. This on balance, likely contributed to his death. As a result a new jejunostomy feeding protocol was implemented in September 2022. Despite this a Datix was never raised and a Duty of Candour letter was not sent to the family in accordance with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the "Regulations"). Furthermore, information about the identification of this clearly relevant issue was not provided to the Coroner ahead of the inquest hearing (which was subsequently adjourned) on 30 June 2023, or in response to any further requests for evidence. It was only when a specific question was put to the Trust by the Coroner in relation to the existence of a protocol and whether it was followed that this information was provided. This was in September 2025, two years after the new protocol had been introduced in direct response to Lee's death. I am concerned that the Trust has not complied with its statutory duty under Regulation 20 of the Regulations; has not provided relevant documentation to the Coroner in

	accordance with its disclosure duties under Schedule 5 of the Coroners and Justice Act 2009 ("CJA"); and has not investigated this incident in accordance with the requirements to do so under Datix. I am concerned that if such omissions exist in other cases that there is a risk of deaths occurring in the future due to a lack of proper incident investigation and adherence to statutory requirements relating to patient safety and investigation of deaths. I would like to understand the governance processes in place at the Trust to ensure that: 1. Incidents are properly investigated via the Trust's internal processes; 2. Regulation 20 - Duty of Candour is complied with; and, 3. Disclosure duties under Schedule 5 CJA are properly adhered to.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 **9 February 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 family. I have also sent it to the CQC who may find it useful or of interest. 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. He may send a copy of this report to any person who he 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.
9	[redacted] **Louise Wiltshire** **15 December 2025**