REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** The Chief Executive Officer, East Suffolk and North Essex NHS Foundation Trust
1	**CORONER** I am Sean Horstead, area coroner, for the coroner area of Essex
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 16th September 2024 I commenced an investigation into the death of Suzanne Pemberton, aged 61 years'. The investigation concluded at the end of the inquest on the 16th December 2025. Suzanne Pemberton died on the 16th September 2024 at Colchester General Hospital (CGH), Turner Road, Colchester, Essex from a cause of death confirmed as: *(1a) pneumonia and sepsis (joint causes),* arising from *(1b) exacerbation of long-standing bronchiectasis*; on a contributory background of *(2): severe depressive disorder, malnutrition and chronic frailty.* The Conclusion of the inquest was a *Narrative Conclusion* focussed on those aspects of the inadequate care, management and treatment provided by Essex Partnership NHS Foundation Trust (EPUT) that probably more than minimally contributed to the death.
4	**CIRCUMSTANCES OF THE DEATH** Over the course of a two-year period preceding her death, there were a number of opportunities for (EPUT) staff and clinicians to escalate concerns regarding Suzanne's mental health, as raised by those treating her in primary and secondary care for her complex physical medical needs arsing, principally, from her chronic Bronchiectasis.

	Suzanne's lack of concordance with her mental and physical health medication informed a pattern of repeated and extended periods of admission as an in-patient to treat her lung infections which, over time and following each hospital discharge, led - in that non-concordance - to chronic and sustained deconditioning consequent upon depleted nutritional and physiological reserves This, in turn, directly contributed to the exacerbation of her chronic lung condition, leading to repeated infections and, ultimately, the fatal pneumonia and sepsis. The evidence confirmed that by the time of her final admission to CGH on Thursday 12th September 2024, such was the extent of the depletion of her physical and nutritional reserves and consequent extreme frailty and deconditioning, that Suzanne's death on Monday 16th September was unlikely to be avoidable. It was apparent, however, that from her admission through until the day of her death on 16th September Suzanne had not been fully assessed in person by the CGH Dietetic team, notwithstanding that she had been referred to dietitians on Friday 13th at 09:01 hours and then re-referred, the same day, at 10:09 hours and had been deemed, when later triaged, as a Category 2 priority to be seen within 24 hours.
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. – Although, in the specific circumstances of this case, the delay in the provision of an in-person dietetic assessment was not a probable causative factor in Suzanne's death, the written evidence of a Senior Gastro/Surgical Dietician, admitted under Rule 23, stated: *"At present there is no funding in place to provide **any** dietetic service for weekends or bank holidays. Wards are encouraged and trained to implement the Malnutrition Universal Screening Time 'MUST' care plans and utilise enteral feeding starter regimes where appropriate whilst awaiting dietetic input." (Emphasis added).* The further written and oral evidence of the Dietic Professional Lead confirmed that CGH only provides *any* form of dietetic in-put during weekday working hours ie between 08.00 hours and 17.00 hours, Monday to Friday (excluding Bank Holidays). The Professional Lead further reconfirmed, in terms, that outside of those hours there is simply *no specialist dietetic service or cover of*

	any kind at all for patients at CGH. In her evidence she told the inquest that whilst there are, to her knowledge, *"different arrangements in different Trusts"* to deal with the provision of *an 'out of hours'* service, ranging from on-site clinicians to the availability of on-call advice, no such service of any kind is available at CGH (with proposals advanced by the Dietetic Team for a new business case for funding having not been taken forward). The Professional Lead gave evidence that, in her view, this lack of service was *"far from ideal"* and further accepted that this will inevitably mean that there will be cases where, as examples, Naso-gastric feeding may not be started as soon as it should be, or that there will occasions when the written generic 're-feeding' guides provided by her Team to the wards may not be appropriately followed (with such failures not being picked up and corrected by her Team). She accepted that in such circumstances this could give rise to the risk of (avoidable future deaths.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 Monday 2nd March 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: *The husband and son of the deceased;* *Essex Partnership University NHS Foundation Trust;* *Suzanne's GP;*

	Suzanne's Consultant Psychiatrist, based at Cambridgeshire University Hospital NHS Foundation Trust. 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 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	***05.01.2026*** ***HM Area Coroner for Essex Sean Horstead***