Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **Colchester General Hospital - East Suffolk and North Essex NHS Foundation Trust**
1	**CORONER** I am Lincoln BROOKES, HM Senior 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 18 February 2025 I commenced an investigation into the death of David James FENN aged 68. The investigation concluded at the end of the inquest on 25 February 2026. The conclusion of the inquest was Natural Causes and it found that: "On 12th February 2025 at Colchester General Hospital, Turner Road, Colchester, Essex, David James FENN died of multi-organ failure secondary to septicaemia which was a consequence of septic arthritis of the left knee (against a background of several other significant contributing comorbidities)."
4	**CIRCUMSTANCES OF THE DEATH** Hospital referral David Fenn, a 68 years old gentleman, was admitted into A&E Dept of Colchester General Hospital on 1st February 2025 with suspected sepsis / septic left knee arthritis. He had a history of previous Total Knee Replacement followed by multiple revision surgeries over many years. His past medical history included Liver Cirrhosis with Portal Hypertension, Advanced Kidney disease Stage, and Atrial Fibrillation (on Edoxaban). Following urgent surgery on 2nd Feb he was admitted to the ICU where he required multiorgan support and antibiotics for severe sepsis but he progressively deteriorated. After ongoing family discussions about his severe condition, he was palliated due to progressive multiorgan failure and failure to respond to treatment. Sadly he died on 12th February 2025 at 10.23 hrs. The Medical Cause of Death was found to be : 1 a) Multi-Organ Failure.. 1 b) Septicaemia 1 c) Septic Arthritis Left Knee 2) Liver Cirrhosis, Portal Hypertension, Advanced Chronic Kidney Disease The Court heard that Mr Fenn had in fact attended Colchester General Hospital a few days earlier with similar symptoms on 28th January 2025 but after several hours he was discharged home. It was accepted by the Hospital that with hindsight he should not have been discharged home and that instead the Sepsis 6 pathway should have been followed and that he should also have had urgent knee surgery to address the source of the sepsis. The Court ruled that whilst it could not be satisfied on the balance of probability that he would

	have survived had he not been discharged on the 28th January, it did observe that he could possibly have survived.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) On the 28th January 2025: 1) Signs of sepsis where not appropriately recognised and the Sepsis 6 Pathway was not followed. 2) An early Consultant Review was not sought. 3) The later attempt to seek the Consultant's views was hampered by the use of a mobile phone which had poor signal in the operating theatre and crucial information was not fully imparted/understood. 4) The junior doctor did not feel able to challenge the view of the Consultant to discharge nor did they seek to reapproach them with fuller information. 5) An alternative Consultant's opinion was not sought. 6) The Multi Disciplinary Team meeting the following morning did not discuss Mr Fenn's case when it should have.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 April 24, 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 [redacted] I have also sent it to [redacted] **- Ellisons Solicitors (Family Solicitor) and Suffolk and North East Essex Integrated Care Board** who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	**Dated: 27/02/2026**  **Lincoln BROOKES** **HM Senior Coroner for** **Essex**