

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	<p><u>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</u></p> <p>THIS REPORT IS BEING SENT TO:</p> <p>The Chief Executive Officer, East Suffolk and North Essex NHS Foundation Trust.</p>
1	<p><u>CORONER</u></p> <p>I am Sean Horstead, area coroner, for the coroner area of Essex</p>
2	<p><u>CORONER'S LEGAL POWERS</u></p> <p>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.</p>
3	<p><u>INVESTIGATION and INQUEST</u></p> <p>On 14th October 2024 I commenced an investigation into the death of Janet Sylvia Daniels, aged 74 years. The investigation concluded at the end of the inquest on the 30th January 2026. Janet Sylvia Daniels died on 6th of October 2024 at Colchester General Hospital, Turner Road, Colchester, Essex from Pulmonary Thromboembolism caused by Sepsis arising from Hickman Line infection on a background of chronic kidney disease 3A and congestive cardiac failure.</p> <p>The conclusion of the inquest was a <i>Narrative Conclusion</i> reflecting the (admitted) shortcomings in the Trust's communication with Mrs Daniels and her family that preceded - and followed - the transition to end of life care and the timing of, and clinical basis for, the withdrawal of active treatment which, in turn, probably impacted the timing of her death.</p>
4	<p><u>CIRCUMSTANCES OF THE DEATH</u></p> <p>Mrs Daniels died from a recognised complication of a necessary medical procedure in the context of significant clinical frailty contributed to by multiple co-morbidities and previous surgical interventions. Her death occurred 6 days after the withdrawal of treatment including intravenous fluids and antibiotics.</p> <p>On Friday 27th September 2024 Mrs Daniels confirmed to her Responsible Clinician - in terms - that, notwithstanding very significant pain levels and concerns about continuing to live with her reduced quality of life, she wished to continue treatment, specifically including an anticipated further six weeks of antibiotic treatment. It was acknowledged by the Trust that she had capacity to</p>

	<p>make these decisions about her immediate future care, management and treatment.</p> <p>On the morning of Saturday 28th September a decision was made by a Specialist Palliative Care Nurse and a Senior Registrar to move Mrs Daniels to end of life care and they initiated an Individualised Care Plan for Last Days of Life (ICPLDL) <i>but did so without clearly relaying or discussing the decision, or explaining (or documenting) the clinical reasons for the decision, to either the (capacitous) patient or her family, including those who held Lasting Power of Attorney for Health and Well-being.</i> (A copy of the LPA had been provided to the Trust on Mrs Daniels' admission). The Trust accepted that there was a failure to communicate appropriately with the family to ensure that they, and Mrs Daniels, fully understood that a transition to 'last days of life' care was deemed clinically appropriate and/or the basis for that decision.</p> <p>The decision appeared to have been made by reference to the patient's presentation over a two-hour period on the morning of the 28th (although the evidence indicated that Mrs Daniels had been sat up in bed that morning, drinking tea, eating cereal and conversing with her family). Neither the patient or her family were informed of potentially relevant clinical features, including Mrs Daniel's significantly improved CRP levels, only very moderately raised white cell count (indicating, according to her Responsible Clinician Consultant, that her Sepsis had stabilised and was controlled) and, for her, her stable kidney function.</p> <p>In this context, the agreement of the family members on Sunday 29th September to discontinuation of intravenous antibiotic treatment was made on the basis of partial and incomplete information. In evidence the family confirmed that such agreement would not have been forthcoming had the fuller clinical picture been explained to them. Her Responsible Clinician Consultant confirmed in evidence that Mrs Daniels would probably not have died on 6th October 2024 had intravenous antibiotics and fluid continued to be administered as she had clearly indicated she wished to happen - and the family would have wished to have happened, had the clinical position been discussed with them as, the Trust accepted, in should have been.</p>
5	<p><u>CORONER'S CONCERNS</u></p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <p>The Trust accepts that there was a significant failure on the part of clinical and nursing staff to communicate effectively with Mrs Daniels and her family in respect to critical clinical decision making, and the basis for such clinical</p>

