

**REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS
2013**

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's [PFD Publication Policy \(2026\)](#).

1.	CORONER I am Victoria DAVIES, Area Coroner, for the coroner area of Cheshire.
2.	DATE OF REPORT 31 July 2026
3.	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.
4.	THIS REPORT IS BEING SENT TO 1. The Royal College of Emergency Medicine You are under a duty to respond to this report within 56 days of the date of this report, namely by September 25, 2026. I, the coroner, may extend the period if an appropriate application is made.
5.	YOUR RESPONSE 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
6.	SUMMARY OF CORONER'S CONCERN I am concerned as to a lack of awareness amongst emergency department

	clinicians of guidelines designed to support clinicians in an acute setting in assessing and managing patients with eating disorders who present with an acute illness.
7.	ACTION SHOULD BE TAKEN In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe you have the power to take such action.
8.	INVESTIGATION AND INQUEST On 21 January 2026 I commenced an investigation into the death of Karen Jayne Graham aged 54. The investigation concluded at the end of the inquest on 31 July 2026. The medical cause of death was 1a anorexia nervosa. The conclusion of the inquest was that Karen died from natural causes. There were no causative failings in care identified for Karen.
9.	CIRCUMSTANCES OF DEATH Karen Graham had a longstanding history of anorexia nervosa, for which she was under the care of the eating disorder team for many years. Her BMI was chronically low and would fluctuate regularly. On 15 January 2026 it was identified that Karen had lost a significant amount of weight since last being weighed on 6 January, although reported no physical health symptoms. A plan was in place for follow up, review and consideration of admission to an eating disorder unit on 19 January. Sadly, Karen was found deceased in bed at her home on 17 January 2026. On 6 November 2025 Karen attended Leighton Hospital feeling weak. She was assessed and, aside from low BP and low BMI, both of which were either long standing or normal for her, no concerning signs were noted. An ECG was undertaken to look for rhythm abnormalities which can occur with poor nutrition and electrolyte disturbances, but this was normal. Karen was discharged. There was no discussion with the mental health team, as Karen refused, and Karen was not weighed. At the time, the team in the emergency department were unaware of the existence of guidelines to support doctors in acute settings in managing patients with eating disorders - <i>Medical Emergencies in Eating Disorders: guidance on recognition and management</i>- I will refer to them as the MEED guidelines. Had they been aware, I found it likely that Karen would have been weighed, or at least been asked if she could be weighed, and a discussion had with the liaison psychiatry team to see whether any further action was required. This would have led to a conversation with her consultant psychiatrist in the eating disorder team. For various reasons, I found it unlikely that this discussion would have resulted in admission for Karen on that date, but it may have prompted further physical health checks in the period which followed. I found that this did not cause or contribute to her death however, as the consultant was well aware of Karen's presentation and risks, and these were explored in more detail in the reviews which followed.

10.	CORONER'S CONCERNS During the course of the inquest I heard evidence 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: <u>Lack of awareness of MEED guidelines amongst emergency department clinicians.</u> It was the evidence of the Consultant in Emergency Medicine that he had not been aware of the MEED guidelines before they were sent to him by the court as part of preparation for the inquest. On discussion with his colleagues, they were also unaware of them. It was his evidence that, whilst the number of patients to whom they apply is very small, it would be very helpful to be aware of the existence of them for future patients. To that end, the team at Leighton Hospital have developed their own local guideline in accordance with the MEED guidelines, which is now available on the trust's intranet. This is then much more accessible and likely to be found by someone with, no knowledge of their existence, is essentially checking if there is a relevant guideline, than if it was not on the intranet. I am concerned that this lack of awareness prior to the inquest is not an issue exclusive to Leighton Hospital. I am aware of a Report to Prevent Future Deaths from December 2021 in the inquest of Nichola Lomax where this was raised as an issue (albeit the guidance at that time was 'MARISPAN') and a report was written to various national organisations, although not the Royal College of Emergency Medicine at that time. A similar issue was raised in a Report to Prevent Future Deaths at the inquest touching the death of Averil Hart in March 2021. The response to the report from November 2021 from the Royal College of Psychiatrists details actions which were being taken to raise awareness. I am concerned that these actions have not been effective, given the lack of knowledge at Leighton Hospital, and that the organisation who are most appropriate to consider this further is the Royal College of Emergency Medicine.
11.	COPIES AND PUBLICATION OF THIS REPORT I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: The family of Ms Graham Cheshire and Wirral Partnership NHS Foundation Trust

	Leighton Hospital/ Mid Cheshire Hospitals NHS FT Royal College of Psychiatrists I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
12.	SIGNATURE  Victoria DAVIES Area Coroner for Cheshire