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 Rebecca MUNDY, HM Assistant Coroner, for the coroner area of Essex.
2.	**DATE OF REPORT** 20 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. [redacted] – Chief Eexcutive Officer, of Mid and South Essex NHS Foundation Trust** You are under a duty to respond to this report within 56 days of the date of this report, namely by **September 14, 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** **See box 10.**

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 each of you have the power to take such action.
8.	**INVESTIGATION AND INQUEST** On 4 August 2025 I commenced an investigation into the death of Margaret Rosina Templeman, 82. The investigation concluded at the end of the inquest on 16 July 2026. The conclusion of the inquest was a narrative conclusion. Margaret died from a combination of natural causes and the effects of a fall at home, resulting in a fractured neck of femur, which more than minimally contributed to her death.
9.	**CIRCUMSTANCES OF DEATH** Margaret was an 82-year-old lady with a number of significant long-term health conditions, including chronic kidney disease, type II diabetes, and heart failure. On 16 July 2025, Margaret was admitted to Southend University Hospital after an accidental fall at home. She suffered a fracture of the left neck of femur. Margaret was admitted under the Orthopaedic Team. Surgery for her hip was considered and further investigations, including an MRI scan, confirmed the fracture. However, concerns later developed around the risks of surgery because of her heart and kidney conditions. Margaret's condition worsened and on 18 July 2025, her kidney function had deteriorated significantly and she had developed a Stage 3 Acute Kidney Injury. Following further blood tests she was diagnosed with urosepsis. Despite treatment, Margaret's condition continued to worsen. By 19 July 2025 following discussions between the treating clinicians and her family about her prognosis and treatment options, it was concluded that further aggressive treatment was unlikely to result in a meaningful recovery. Margaret received palliative care until her death on 24 July 2025.
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: CORONER'S CONCERNS During the course of the inquest the evidence revealed matters giving rise to concern and 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: Concern 1: Inadequate Clinical Record Keeping During the course of this investigation I heard evidence of significant

	deficiencies in the maintenance of clinical records relating to hydration, nutrition, communication, observations, medication management and aspects of clinical decision making. The deficiencies were such that I was unable to determine whether important elements of care had been provided appropriately, or at all. This is not an isolated concern. I have encountered similar failings in record keeping and documentation in other inquests involving different wards and hospital sites within the Trust, as have other Coroners within this jurisdiction. I am concerned that inadequate clinical records create a risk that deterioration in patients may not be identified promptly, that care may not be delivered consistently, that clinical decisions may not be appropriately informed, and that subsequent investigations into patient safety incidents are hindered. Concern 2: Failure to Document Communication and Escalation Evidence revealed little or no documentation of communication with family members, discussions regarding changes in treatment plans, surgical cancellations, concerns raised or information shared by relatives, or internal communication between healthcare professionals. Family members in this case provided supporting information about Margaret's conditions and raised concerns regarding her deterioration which ultimately preceded the diagnosis of sepsis, yet there was limited documentation of their instructions or concerns or any action taken in response. I am concerned that failures to record and communicate information effectively between staff and with families create a risk that important clinical information may be lost, deterioration may not be recognised or acted upon, and opportunities to intervene may be missed. Concern 3: Reliability of Patient Safety Assurance Processes The Trust's own review identified learning regarding communication, documentation and the timing of treatment. However, evidence heard during the inquest revealed additional shortcomings that were either not identified or could not be fully explored because of inadequacies in the contemporaneous records. I am concerned that where record keeping is poor, the Trust may be unable to accurately assess the quality and safety of care delivered, identify learning, or assure itself that risks have been addressed. Concern 4: Trust-Wide Nature of the Issue I am concerned that the documentation and communication failures identified in this case may not be confined to a single ward, clinical team or hospital site. Similar concerns have arisen in multiple inquests heard by this Court involving different areas of the Trust. In circumstances where recurring deficiencies are being identified across multiple services, there is a risk that systemic shortcomings exist in relation to record keeping, documentation standards, clinical communication and oversight. Unless effective action is taken, there remains a risk that future patients may suffer harm and that future deaths may occur.
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: *[please do not use individual's names, but instead roles/titles]* • [redacted] **– Daughter** • [redacted] **- Son** 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** [redacted] **Rebecca MUNDY** **HM Assistant Coroner for Essex**