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 Stephen SIMBLET, HM Assistant Coroner, for the coroner area of Essex.
2.	**DATE OF REPORT** 15 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. Basildon University Hospital Trust 2. [redacted] You are under a duty to respond to this report within 56 days of the date of this report, namely by September 09, 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**

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 09 February 2024 I commenced an investigation into the death of Millie Jade HOOK aged 19. The investigation concluded at the end of the inquest on 14 July 2026. The conclusion of the inquest was that: The deceased died in hospital, having suffered a cardiac arrest while awaiting further care in the hospital. The deceased, who was a comparatively young and fit patient aged 19 years old at the time she died, had suffered a bout of ill-health at home from a viral type of illness. She had suffered bouts of diarrhoea and vomiting, and had at times suffered apparent fainting. Having sought medical advice, an ambulance had been sent to her home, where it was immediately realised that she was seriously unwell and needed to go to hospital. The deceased was taken to Basildon Hospital by ambulance, and had deteriorated during her journey to hospital such that the paramedics transporting her considered that she needed immediate attention for a serious sepsis- like presentation. Despite the prior communication of the seriousness of her illness and its continuing deterioration, there were some delays in receiving her into hospital due to the emergency department staff not wishing to admit her to hospital until a doctor visited the ambulance and saw the seriousness of her condition. Following her admission, the deceased was treated with significant levels of fluid, and a plan of providing her with fluids, catheterising her, monitoring her oxygen saturations, blood pressure and blood gases and other measurements, and then to refer her to the Intensive Treatment Unit/ Critical Care Unit ("CCU"). The deceased did not receive her catheter until many hours after her admission, and nor were the measurements of her blood being monitored, or the implications of those readings acted upon with any degree of immediacy or sufficient appreciation of the seriousness of the deceased's condition. The deceased was not in fact transferred to the CCU at any point, despite the deceased continuing to deteriorate and becoming increasingly unwell. Throughout her stay in hospital, the deceased was inadequately monitored, with readings of these measurements being inadequately recorded and insufficient attention paid to the implication of those measurements. Overall, the severity of the deceased's illness and its continuing worsening despite the interventions of these treatments were not sufficiently appreciated. Even though at some stage the doctor treating her in the emergency department considered that the deceased should be transferred to the CCU, the deceased was not transferred, in part due to a conflict between the hospital departments as to whether this very unwell patient met the criteria to be in CCU, but in any

	event, the failure to transfer the deceased either immediately, or within a period of around an hour after her arrival at the hospital, was a serious failure to provide her with appropriate and necessary medical treatment. Had the deceased received such treatment, she would, on the balance of probabilities, have survived. At around 00:45, the deceased collapsed in cardiac arrest, from which resuscitation efforts were unsuccessful. The deceased died at 01:45 hours on 28th January 2024 in the resuscitation area of the hospital. The conclusions of the inquest consisted of judgmental narrative findings, and a conclusion of death by natural causes contributed to by neglect.
9.	**CIRCUMSTANCES OF DEATH** The deceased died in hospital, having suffered a cardiac arrest while awaiting further care in the hospital. The deceased, who was a comparatively young and fit patient aged 19 years old at the time she died, had suffered a bout of ill-health at home from a viral type of illness. She had suffered bouts of diarrhoea and vomiting, and had at times suffered apparent fainting. Having sought medical advice, an ambulance had been sent to her home, where it was immediately realised that she was seriously unwell and needed to go to hospital. The deceased was taken to Basildon Hospital by ambulance, and had deteriorated during her journey to hospital such that the paramedics transporting her considered that she needed immediate attention for a serious sepsis- like presentation. Despite the prior communication of the seriousness of her illness and its continuing deterioration, there were some delays in receiving her into hospital due to the emergency department staff not wishing to admit her to hospital until a doctor visited the ambulance and saw the seriousness of her condition. Following her admission, the deceased was treated with significant levels of fluid, and a plan of providing her with fluids, catheterising her, monitoring her oxygen saturations, blood pressure and blood gases and other measurements, and then to refer her to the Intensive Treatment Unit/ Critical Care Unit ("CCU"). The deceased did not receive her catheter until many hours after her admission, and nor were the measurements of her blood being monitored, or the implications of those readings acted upon with any degree of immediacy or sufficient appreciation of the seriousness of the deceased's condition. The deceased was not in fact transferred to the CCU at any point, despite the deceased continuing to deteriorate and becoming increasingly unwell. Throughout her stay in hospital, the deceased was inadequately monitored, with readings of these measurements being inadequately recorded and insufficient attention paid to the implication of those measurements. Overall, the severity of the deceased's illness and its continuing worsening despite the interventions of these treatments were not sufficiently appreciated. Even though at some stage the doctor treating her in the emergency department considered that the deceased should be transferred to the CCU, the deceased was not transferred, in part due to a conflict between the hospital departments as to whether this very unwell patient met the criteria to be in CCU, but in any event, the failure to transfer the deceased either immediately, or within a

	period of around an hour after her arrival at the hospital, was a serious failure to provide her with appropriate and necessary medical treatment. Had the deceased received such treatment, she would, on the balance of probabilities, have survived. At around 00:45, the deceased collapsed in cardiac arrest, from which resuscitation efforts were unsuccessful. The deceased died at 01:45 hours on 28th January 2024 in the resuscitation area of the hospital. The conclusions of the inquest consisted of judgmental narrative findings, and a conclusion of death by natural causes contributed to by neglect.
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: (1) There is a concern that the systems for dealing with patients in the Emergency Department at Basildon Hospital presenting with acute physiological derangement and who are clearly unwell, is inadequate. This includes (a) the appropriate emergency care pathway and the effectiveness of the interface between the hospital teams and departments. (b) There is also concern that cases are not being appropriately escalated to senior clinicians in a timely manner ; (2) There is a concern that those working in substantive consultancy posts at Basildon Hospital and other hospitals in the Trust, including in departments to which critically ill patients may be taken and where the care that such patients receive might affect whether they survive or not, do not hold the appropriate consultant registration standard and that the continued employment of such consultants on a long- term basis does not meet the appropriate NHS standards for holding and maintaining employment in such positions; (3) There is a concern over the effectiveness and sufficiency of the Trust's arrangements for investigating cases where patients have died or where there have been other serious outcomes, including not properly obtaining and considering additional clinical opinion, not investigating promptly and seeking to sufficiently to implement learning from such incidents. (4) There is a concern as to whether there is a pro- forma sepsis protocol in use at Basildon Hospital, and if there is, how this protocol is being deployed and whether clinical interventions pursuant to this protocol are being adequately recorded.
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]*  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**  **Stephen SIMBLET** **HM Assistant Coroner for** **Essex**