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 Simblett, HMC Assistant Coroner, for the coroner area of Essex.
2.	**DATE OF REPORT** 12th June 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. ESNEFT - East Suffolk and North Essex NHS Foundation Trust 2. Addenbrooke's Hospital 3. PFD Regulation 28 NHS You are under a duty to respond to this report within 56 days of the date of this report, namely by August 07, 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** There is a concern as to how clinicians caring for transplant patients in non-specialist hospitals can obtain sufficiently up- to- date blood test results. Not having reliably up- to- date results can, with the complexities that such patients present, mean that a patient's chance of survival is affected.
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 07 November 2024 I commenced an investigation into the death of Suzanne FREDERICKS aged 41. The investigation concluded at the end of the inquest on 04 June 2026. The conclusion of the inquest was that: The deceased, who had previously had a liver transplant, suffered liver and kidney problems. She was admitted into Colchester General Hospital for treatment. That treatment was unsuccessful and the deceased died in that hospital on 4th November 2024.
9.	**CIRCUMSTANCES OF DEATH** The deceased, who had previously had a liver transplant, suffered liver and kidney problems. She was admitted into Colchester General Hospital for treatment. That treatment was unsuccessful and the deceased died in that hospital on 4th November 2024. The conclusion of the inquest was death by natural causes. The inquest heard that the complexity of this patient and the immuno-suppressant drugs that she was being treated with following her transplant was particularly challenging. The nephrologists and other specialists involved in her care needed extremely contemporaneous and informed medical information about the effects of those drugs on the patients' condition. Some of the treating doctors felt that the time taken to process laboratory results was affecting their ability to advise the appropriate clinical treatment for the deceased.
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: There is a concern as to how clinicians caring for transplant patients in non-specialist hospitals such as Colchester General Hospital can obtain sufficiently up- to- date blood test results. Not having reliably up- to- date results can, with the complexities that such patients present, mean that a patient's chance of survival is affected. The arrangements for taking, processing and returning

	sample results in Colchester General Hospital (and for that matter, other hospitals in the UK) may need to be improved.
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]* • **Father** • **Partner** • **Associate, Clyde and Co (Representing Addenbrookes)** • **Deputy Claims and Inquest Manager, Addenbrookes Hospital** • **Legal Manager Claims and Inquests, East Suffolk and North Essex NHS Foundation Trust** 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 Simblett** **HMC Assistant Coroner** **Essex**