The Princess Alexandra Hospital
Hamstel Road
Harlow
Essex
CM20 1QX

18th August 2026

Dear HM Stephen Simblet (Assistant Coroner),

Re: Prevention of Future Deaths Report – Dated 02/07/2026

Princess Alexandra Hospital NHS Trusts response to the above Prevention of Future deaths Report as follows:

1. Clinical staff at PAHT do not understand and do not complete the appropriate recording of DNACPR decisions

The Trust accepts that the review identified shortcomings in the documentation and recording of the DNACPR decision in this case.

The Trust's DNACPR policy states that the decision to complete a DNACPR form is made by the most senior clinician in charge of the patient's care. This may be a Consultant, another doctor or a Specialty Trainee at ST3 level or above who has delegated responsibility. Once the decision is made, it must be fully recorded on the DNACPR form, and the form must be reviewed, endorsed and countersigned by the patient's Consultant within 48 hours of the decision being implemented. On this occasion, the Trust did not follow the policy, as the DNACPR form and decision was not endorsed by the Consultant within 48 hours of completion or implementation.

The Cardiac Arrest Review Panel concluded that the contemporaneous records did not sufficiently demonstrate the clinical reasoning underpinning the decision, the factors considered, or how the anticipated benefits and burdens of CPR had been assessed in the context of the patient's overall clinical condition.

The review further identified that where a potentially reversible factor, namely hyperkalaemia, was part of the rationale for the DNACPR decision, there was

insufficient evidence of a documented reassessment when that condition subsequently improved.

In response, the Trust has undertaken a review of its resuscitation decision-making processes and has implemented a digital ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) system across the organisation. This provides a standardised electronic platform for recording DNACPR and escalation decisions, ensuring greater visibility, accessibility and consistency of documentation.

The Trust has reinforced to clinical staff that:

- DNACPR decisions must be supported by a clearly documented, individualised assessment of the patient's overall clinical condition, prognosis and likely outcome from CPR.
- All documented DNACPR decisions and forms must be endorsed by a Consultant within 48 hours of completion or implementation.
- The rationale for decisions must be contemporaneously recorded, including discussion with the patient and/or those close to them where appropriate.
- Individual comorbidities, including obesity, must not be used in isolation as justification for a DNACPR decision.
- DNACPR decisions are dynamic and must be formally reviewed when there is a material change in the patient's clinical condition, particularly where potentially reversible factors formed part of the original decision-making process.
- Senior multidisciplinary review should be considered in complex cases and the agreed ceiling of treatment clearly documented.

In addition, the Trust is reviewing its Resuscitation and ReSPECT policies and strengthening education for medical and nursing staff regarding DNACPR decision-making, documentation standards, review requirements and compliance with Resuscitation Council UK guidance.

Audit of ReSPECT documentation will continue to form part of ongoing governance arrangements to provide assurance that documentation standards are maintained, and areas of learning identified promptly.

2. Regarding capacity assessment, PAHT staff have uncertainty as to how best to approach a mental capacity assessment in patients with a mental health background who are non-compliant or demonstrate fluctuating compliance with medical treatment

The Trust acknowledges the concern identified by the Coroner regarding uncertainty in the assessment of mental capacity where patients have a diagnosed mental health condition and are refusing or inconsistently accepting potentially life-saving treatment.

The Trust wishes to clarify that under the Mental Capacity Act 2005, responsibility for assessing capacity in relation to a specific medical treatment decision rest with the clinician proposing that treatment. The presence of a mental health diagnosis does not automatically indicate a lack of capacity, and capacity must be assessed on a decision-specific and time-specific basis.

Following review of this case, the Trust has reinforced the following principles:

- Patients with mental health conditions should be presumed to have capacity unless assessment demonstrates otherwise.
- Where a patient is refusing treatment or displaying fluctuating compliance, a structured Mental Capacity Assessment must be undertaken regarding the specific treatment decision in question.
- The assessing clinician must determine whether the patient can understand, retain, use or weigh information relevant to the decision and communicate their decision.
- If capacity is established, the patient's decision must be respected, even where family members or healthcare professionals disagree with that decision.
- If capacity is lacking, decisions must be made in the patient's best interests in accordance with the Mental Capacity Act, involving the patient where possible, family members, carers, advocates and relevant members of the multidisciplinary team.

The Trust has clarified escalation routes for staff requiring additional support. Where there is disagreement regarding capacity, best-interest decisions or treatment plans, escalation should occur through senior clinical review and multidisciplinary discussion, including specialist advice where required.

The role of mental health professionals is advisory and supportive; responsibility for determining capacity for a medical treatment decision remains with the treating clinical team.

Mental health practitioners may, however, provide valuable information regarding the patient's mental disorder, presentation, communication needs and previous functioning.

To address the concern identified by the Coroner, the Trust is strengthening education and guidance for clinical staff through Mental Capacity Act training, targeted learning from this case, and development of clearer guidance regarding the assessment of capacity in patients with mental illness who refuse or inconsistently accept treatment.

This will include clarification of when and how to obtain specialist mental health advice, escalation pathways, documentation requirements and best-interest processes.

These actions are intended to ensure clinicians are supported to undertake robust, legally compliant and patient-centred capacity assessments while maintaining appropriate access to specialist mental health expertise where required.

The Trust is satisfied that these actions will strengthen clinicians' confidence in undertaking Mental Capacity Act assessments in patients with mental illness, improve documentation and escalation processes, and ensure that decisions regarding refusal of treatment are made consistently, lawfully and in accordance with the principles of the Mental Capacity Act 2005. The Trust will monitor implementation through training compliance, clinical governance processes and learning from incidents

We trust that this response provides the Court with clear assurance that the Trust has fully considered the matters raised, has taken appropriate and proportionate action, and will continue to monitor compliance through its established clinical governance processes.

Yours sincerely,

[redacted]

[redacted]
Chief Executive Officer

[redacted] Chief Medical Officer
[redacted] Chief Nursing Officer (Interim)