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** 02 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. Chief Executive of The Princess Alexandra Hospital NHS Trust 2. Chief Executive of Essex Partnership University NHS Foundation Trust You are under a duty to respond to this report within 56 days of the date of this report, namely by August 27, 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 20 May 2024 I commenced an investigation into the death of Luciana Antonia GIANFRANCESCO aged 52. The deceased died in Princess Alexandra Hospital, Harlow, following admissions for pneumonia and other health problems. An inquest was heard, but adjourned after most of the evidence had been called. Evidence has been called relating to the way in which Do Not Attempt Cardiopulmonary Resuscitation assessment and documentation had been performed, and evidence has also been called in relation to the way in which arrangements for assessing capacity to accept or refuse treatment is assessed, and the role of mental health professionals in such decisions in relation to patients with a previous mental health history. Further evidence in relation to resuscitation procedures is now to be obtained, but I consider that it is appropriate to make this Report at this stage.
9.	**CIRCUMSTANCES OF DEATH** The deceased died in Princess Alexandra Hospital, Harlow following admissions for pneumonia and other health problems. She had a number of illnesses, including a well- established psychiatric diagnosis of established diagnosis of Schizoid Personality Disorder and Dependent Personality Disorder and was being treated in the community with antidepressant and antipsychotic medication and with a care co- Ordinator. Her mental health care was provided by Essex Partnership University Trust (EPUT), who are also responsible for liaison psychiatry in the Princess Alexandra Hospital. While the deceased was in hospital, there were concerns over her ability to accept or refuse life- saving treatment. Those led to various measures to consider her capacity. On 17th April 2024, the treating team sought to assess her capacity and to invite, at very short notice, members of the Liaison Psychiatry team and also her care co- Ordinator to assist them in those decisions. None of those people were able to attend. The clinical team considered that the deceased had capacity to refuse treatment, although the deceased's family and professional staff from the supported living placement at which the deceased lived were concerned that she did not have capacity to refuse treatment. Formal capacity assessment recording this decision was completed on 17th April by a registrar. A further meeting was convened on 19th April 2024, at which the Care Co- Ordinator was present, but where there is a lack of clarity about her role, and where evidence given to the inquest by senior EPUT staff raised doubts about the appropriateness of the Care Co- Ordinator being asked to fulfil this role. Following that meeting, the treating team considered

	that the patient had capacity to refuse treatment, and as a result, there were some delays in implementing life- saving treatment, albeit that the patient did subsequently agree to receive such treatment. There was also evidence given that one of the treating doctors for the deceased had, incompletely, filled in a DNACPR form on behalf of the deceased which had become part of her ongoing care plan. The fact of this was not known to the consultant in charge of the deceased's care. That form, which was dated 18th April, suggested that the doctor (also involved in 17th and 19th April capacity assessments and who had completed the 17th April form recording that the patient had capacity) considered that the patient lacked capacity to decide whether or not to be resuscitated and that there was "Family agreement" that the patient should not be resuscitated. The Family did not in fact know of the existence of this form. Further, although the doctor had ticked boxes stating that the patient lacked capacity, he had not addressed the section of the form relating to assessment of best interests and mental capacity, nor passed the form to the more senior doctor to sign it off. The summary of the patient's clinical problems was obesity, comorbidities, hyperkalaemia [excess potassium]", upon which the doctor had decided that DNA CPR was in the best interests. It is a feature of this process that the doctor considered that the patient lacked capacity for this form and this decision on this day, but that such lack of capacity was sandwiched between days when the patient was thought to possess capacity to refuse treatment. It emerged very late on in proceedings that national guidelines on resuscitation do not (though further evidence is being called about this) seek to exclude resuscitation attempts on account of a patient's obesity.
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 at Princess Alexandra Hospital there is some uncertainty as how best to approach the assessment of mental capacity in relation to patients who are either non- compliant or inconsistently compliant with necessary life- saving treatment, and a concern as to the procedures for obtaining advice and assistance, if any, from psychiatric professionals, including those involved in the care and treatment of patients with a background of mental disorder. (2) There is a concern that clinical staff at Princess Alexandra Hospital do not fully understand or apply the procedures for investigating, evaluating and recording "Do Not Attempt Cardiopulmonary Resuscitation" decisions and for those treating patients to be informed of such decisions. (3) There is a concern as to whether the procedures, policies and practices at Princess Alexandra Hospital in relation to the provision of Cardiopulmonary Resuscitation are in compliance with national standards, in relation to the treatment patients considered to be clinically obese.

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]* • **Family** • **All Interested Persons** 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] [redacted] **HM Assistant Coroner for Essex**