REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** The Chief Executive of University Hospital Lewisham
1	**CORONER** I am Briony Ballard, Assistant Coroner, for the coroner area of Inner London South
2	**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.
3	**INVESTIGATION and INQUEST** On 23 November 2019 this jurisdiction commenced an investigation into the death of Mr Francis Hodge. The investigation concluded at the end of the inquest on 30 August 2019. The conclusion of the inquest was that Mr Hodge died as a result of the unintended consequences of medical treatment.
4	**CIRCUMSTANCES OF THE DEATH** Mr Hodge died on 16 November 2018 at University Hospital Lewisham due to a perforated colon. Seven days prior Mr Hodge had undergone an elective laparoscopic repair of multiple incisional hernias. These had developed at the site of previous abdominal surgeries. Additionally Mr Hodge suffered with pre-existing diverticular disease. The surgery had proceeded without complication. The subsequent development of the perforation was within an area away from the operation site and was very unexpected. It is likely it represented the coincidence of a bowel rendered vulnerable by pre-existing pathology returning to normal bowel function following surgery.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will 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) At inquest I was told that on discharge Mr Hodge was given inadequate discharge advice. He was advised to rest as much as possible and that if he were to remain in severe pain in a week's time he should return. (2) The consultant who undertook the surgery explained that such discharge advice was not what should have been provided to a patient following this surgery. The patient should have been told to be concerned about and to look out for: breathlessness, pus or redness, and / or pain which would not settle. (3) Mr Hodge was suffering breathless the night before his collapse and pain which would not settle. He however, did not want to seek medical advice I am told,

	because he was following what he had been told to do on discharge. (4) I was also told that no patient information leaflet existed for this type of surgery as it was not a common type of procedure.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 13 November 2019. I, the coroner, may extend the period. 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Person [redacted], the deceased's son. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	24 September 2019 *Briony Ballard* **[DATE]** **[SIGNED BY CORONER]**