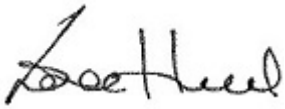
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Secretary of State for Health and Social Care** **University Hospitals Birmingham NHS Foundation Trust**
1	**CORONER** I am Louise Hunt, Senior Coroner for Birmingham and Solihull
2	**CORONER'S LEGAL POWERS** I make this 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 10 November 2022 I commenced an investigation into the death of Hilary THOMAS. The investigation concluded at the end of the inquest . The conclusion of the inquest was:- Died from an ischaemic bowel which went undiagnosed when she attended hospital for a second time on 29/10/22.
4	**CIRCUMSTANCES OF THE DEATH** The deceased attended Birmingham Heartlands Hospital emergency department on 28/10/22 with intermittent abdominal pain for 24 hrs. She was known to suffer from constipation and diverticulitis, hypertension, arthritis and had a previous hysterectomy. All tests were normal and she was reviewed by the OPAL team at 12.15 when she was noted to be pain free so she was discharged home at 15.15. She reattended the emergency department on 29/10/22 and was referred to the surgical team who reviewed her at 11.30. She complained of colicky abdominal pain and was passing wind but had not had bowels open for 4 days. She was complaining of severe pain but had normal observations and the initial diagnosis was acute diverticulitis. However the doctor was contemplating CT scan but incorrectly decided to wait for blood test results before proceeding. Due to workload the doctor came to review blood tests results at 20.00 but which time she had self discharged. These showed a slightly raised white cell count however the clinical decision at time was that she did not need to be recalled. During this attendance no clear plan was set out in the records about how to proceed with her care and the extent of her pain coupled with reattendance was not identified as indicating she was a high risk patient and her case was not escalated for consultant review. On balance a CT scan should have been arranged at this time which would have identified the condition and provided an opportunity for earlier surgery. She represented on 30/10/22 shocked and profoundly unwell with suspicion of an ischaemic bowel which was confirmed on CT scan and found to be due to adhesions constricting the bowel from previous hysterectomy surgery. She was rushed to theatre where the ischaemic bowel was resected; however, she failed to recover and sadly passed away on 31/10/22. Had her condition been identified as it should have been on 29/10/22 she would have likely survived emergency surgery. Based on information from the Deceased's treating clinicians the medical cause of death was determined to be: **1a Sepsis and Multiorgan Failure** **1b Ischaemic bowel, Small bowel volvulus secondary to adhesions (operated)** **1c**

	II
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. **Department of Health and Social care** 1. Witnesses explained at the inquest that the volume of patients attending hospital is at a level the like of which has never been seen and current resources are unable to deal with that volume. This had a direct impact on Mrs Thomas's death as the doctor treating her was unable to review her blood tests results until the evening handover, 6 and a half hours after the results were available by which time Mrs Thomas had left the department. **University Hospitals Birmingham NHS Foundation Trust** 2. Mrs Thomas reattended hospital with severe pain, was over age 70 and an unscheduled return within 72 hours. The Doctor should have considered and followed national guidance from the Royal College of Emergency medicine published in June 2016 (consultant sign off) which confirmed Mrs Thomas should have been reviewed by a consultant. Mrs Thomas was not escalated for consultant review. There was no evidence at the inquest that this guidance has been adopted by the Trust nor that staff are aware of it and have been trained on it. 3. The doctor treating Mrs Thomas on her second attendance decided to wait for blood test result before ordering a CT scan under the misunderstanding that these were required to assess the possibility of renal toxicity from dye used during the scan. The inquest heard evidence that a CT scan should have been undertaken and there was no need to wait for blood test results. This raised a concern that staff at the Trust are unaware of this guidance.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 23 August 2023. 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 Persons: Mrs Thomas's family I have also sent it to the Medical Examiner, ICS, NHS England, CQC, who may find it useful or of interest. 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	**28 June 2023** Signature:  **Louise Hunt** **Senior Coroner for Birmingham and Solihull**