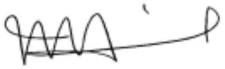
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Regenesis Health Travel Limited**
1	**CORONER** I am Jacqueline DEVONISH, Senior Coroner for the coroner area of Cheshire
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 28 July 2022 I commenced an investigation into the death of Emma Louise MORRISSEY aged 44. The investigation concluded at the end of the inquest on 31 August 2023. The conclusion of the inquest was that: Narrative Conclusion - Died as a result of a massive uncontrolled bleed caused by an instrument perforation within the abdomen during surgery.
4	**CIRCUMSTANCES OF THE DEATH** On 06 July 2022 Emma Louise Morrissey flew to Turkey's private Termessos Hospital in Antalya for gastric sleeve surgery. Arrangements were made through a health tourism company Regenisis. On 07 July 2022 Emma was operated. The surgeon perforated her abdomen with an instrument. The area was packed to stem the bleed but no platelets for blood clotting were administered causing continued bleeding and her sad death on 08 July 2022 at 12:45 hours.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters 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: (brief summary of matters of concern) 1. The health tourism company Regenesis UK relied upon patient self declaration of health and made no independent enquiries to satisfy themselves that Emma was fit for the gastric sleeve procedure before making the arrangement for her to have surgery at the Termessos Hospital, Antalya in Turkey. 2. The series of health related pre-assessment questions asked before referral to the private hospital in Turkey were unclear, as there was no evidence of a standard form produced by a medically trained source for the referring staff to refer to. The questions did not include an enquiry about family history of medical conditions such as cardiac related relevant to Emma.

	3. There has been no evidence of an investigation into the operating table death by the Ministry of Health in Turkey, the private Termessos Hospital or Regenesis UK despite Regenesis having been informed that the death had been caused by the surgeon during the operation. 4. The embalming process for repatriation from Turkey to the UK was inadequate due to there being no evidence of fluid perfused to the great vessels, leaving Emma's body at risk of infection during transit. This presented a risk of decomposition as well as a health risk to the professionals receiving her body in the UK. 5. The surgery note provided to Regenesis stated that the sleeve gastrectomy operation was not completed following the intra-abdominal bleed in the omentum. The UK post mortem confirms that the surgery had been completed and that the site of the bleed was the lieno-renal ligament and not the omentum. The lieno-regal ligament site had been packed to stem the bleed during the operation and was present at post mortem. 5. The cause of death reported in Turkey was natural. It was recorded as 1a, Cardigenic Shock, due to 1b. Disseminated Intravascular Coagulation. In the circumstances of a massive bleed in the abdomen following the introduction of the instrument known as the optical trocar, the death is regarded as unnatural. The evidence before the inquest was that three incisions had been made to the abdomen, two of which with a sharp instrument.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 October 30, 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 **Warrington Borough Council** **Private Termessos Hastanesi** [redacted] I have also sent it to **Foreign, Commonwealth & Development Office** who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	**Dated: 04/09/2023**  **Jacqueline DEVONISH** **Senior Coroner for** **Cheshire**