**IN THE SURREY CORONER'S COURT**
**IN THE MATTER OF:**

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**The Inquest Touching the Death of Wendy HAMMON**
**A Regulation 28 Report – Action to Prevent Future Deaths**

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| 1 | **THIS REPORT IS BEING SENT TO:**<br><br>[redacted]<br>Interim Chief Executive<br>Ashford and St. Peter's Hospitals NHS Foundation Trust<br>[redacted] |
| 2 | **CORONER**<br>Miss Anna Crawford, H.M. Assistant Coroner for Surrey |
| 3 | **CORONER'S LEGAL POWERS**<br>I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009. |
| 4 | **INQUEST**<br><br>An inquest into Mrs Hammon's death was opened on 27 October 2022. The inquest was resumed on 24-25 June 2024 and concluded on 12 July 2024.<br><br>The medical cause of Mrs Hammon's death was:<br><br>1a. Multi-Organ Failure<br><br>1b. Non-Occlusive Mesenteric Ischaemia |

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| | 1c. Small Bowel Obstruction due to Adhesions from Previous Surgery (2011)<br>2. Chronic Kidney Disease<br><br>The inquest concluded with a narrative conclusion as follows:<br><br>Mrs Hammon had a past medical history which included chronic kidney disease.<br>In 2011 she had developed ischaemic bowel, due to Streptococci A, and had undergone surgery to remove a portion of her bowel and to create an ileostomy. As a result of the procedure in 2011 she developed scar tissue known as adhesions, which are a recognised complication of the procedure.<br>On 30 August 2022 Mrs Hammon was admitted to St. Peter's Hospital with abdominal pain, vomiting and a non-functioning stoma. She was diagnosed with, and treated non-operatively for, a small bowel obstruction caused by the adhesions from her surgery in 2011.<br>At approximately 15:30 on 5 September 2022 Mrs Hammon began to complain of severe abdominal pain and at 17:52 a CT scan was requested to investigate the cause of the pain. Thereafter, the plan was for the oncoming night shift to arrange for a senior clinical review of Mrs Hammon and to chase the CT scan. However, the plan was not implemented and Mrs Hammon was not seen by the oncoming night shift until 01:00 on 6 September 2022 when she was found to have blood and pus coming out of an old surgical scar, for which she was commenced on intravenous antibiotics.<br>At 02:41 on 6 September 2022 the CT scan was reported as being strongly suggestive of mesenteric iscahaemia with infarction complicating a known small bowel obstruction and thereafter at 10:50 on 6 September |

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| | 2022 Mrs Hammon underwent an emergency laparotomy, during which the surgical team found widespread ischaemic bowel, and resected a significant amount of her small bowel.<br>On 7 September 2022 a further relook laparotomy was carried out after which Mrs Hammon was cared for on the Intensive Care Unit, however, her condition deteriorated and she died at St. Peter's Hospital on 9 September 2022.<br>Her death was due to Multi-Organ Failure due to Non Occlusive Mesenteric Ischaemia. The ischaemia was caused by the small bowel obstruction which in turn was caused by adhesions from her surgery in 2011.<br>The small bowel obstruction caused the ischaemia firstly by impairing the blood flow within the lining of the bowel and secondly by causing Mrs Hammon to become dehydrated, due to vomiting and reduced fluid absorption from the bowel, which in turn led to her developing hypovolaemia, acute kidney injury and low blood pressure, which prompted her body to reduce the blood supply to the bowel in order to protect other major organs.<br>Mrs Hammon's death was contributed to by her Chronic Kidney Disease which made her more susceptible to developing acute kidney failure.<br>During the period from 1 September 2022 onwards there was a failure to accurately monitor Mrs Hammon's fluid input and output which led to a failure to provide her with adequate fluid replacement, which contributed to her developing dehydration and related bowel ischaemia.<br>During the same period there was a failure to identify that Mrs Hammon's blood tests showed high CRP levels, which is a non-specific inflammatory marker and can be consistent with bowel ischaemia. |

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| | By 4 September 2022 the clinical team caring for Mrs Hammon ought to have recognised that she had ongoing unexplained high CRP levels, in the context of an ongoing small bowel obstruction, with ongoing vomiting, a return of abdominal discomfort and a deteriorating kidney function.<br>Those matters ought to have prompted a senior clinical review and a CT scan which would have diagnosed bowel ischaemia and resulted in emergency surgery on 4 September 2022. Had Mrs Hammon been taken for surgery on 4 September 2022 she would have survived.<br>On the afternoon of 5 September, when Mrs Hammon developed severe abdominal pain, she ought to have received a senior clinical review which would have prompted an expedited CT scan which would have diagnosed ischaemia and would have resulted in emergency surgery on the night of 5 September 2022. Had Mrs Hammon been taken for surgery on 5 September 2022 she would have survived.<br>Mrs Hammon's death was contributed to by neglect. |

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| 5 | **CIRCUMSTANCES OF THE DEATH**<br><br>The circumstances of Mrs Hammon's death are set out in the narrative conclusion above. |

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| 6 | **CORONER'S CONCERNS**<br><br>The **MATTER OF CONCERN** is:<br><br>1. Mrs Hammon's rising CRP was not noted by any member of the clinical team – whether junior or senior - who saw Mrs Hammon during the period from 1 September onwards, despite rising CRP being a potential indicator of ischaemia in patients who are being conservatively managed for small bowel obstruction. The court is concerned that this was not an individual error and may be reflective of a wider lack of knowledge within the team.<br>2. The fluid input and output charts completed for Mrs Hammon were inadequate and could not be relied upon to accurately assess her fluid input and output.<br>3. The Early Warning Scores (NEWS2 Scores) for Mrs Hammon were often incomplete.<br><br>The court did not receive any reassurance from the Trust during the course of the inquest that these matters have been addressed following Mrs Hammon's death. |
| 7 | **ACTION SHOULD BE TAKEN**<br>In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action. |
| 8 | **YOUR RESPONSE**<br>You are under a duty to respond to this report within 56 days of its date; I may extend that period on request.<br><br>Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed. |

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| 9 | **COPIES**<br>I have sent a copy of this report to the following:<br><br>1. [redacted], Interim Chief Executive, Ashford and St. Peter's Hospitals NHS Foundation Trust<br>2. Chief Coroner<br>3. Mrs Hammon's family |
| 10 | **Signed:**<br><br>**ANNA CRAWFORD**<br><br>**Anna Crawford**<br>**H.M Assistant Coroner for Surrey**<br>**Dated this 30th day of July 2024** |