# Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

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| | **REGULATION 28 REPORT TO PREVENT DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1 The Chief Executive, York & Scarborough Teaching Hospitals NHS Foundation Trust.** |
| **1** | **CORONER**<br><br>I am Catherine CUNDY, Area Coroner for the coroner area of North Yorkshire and York |
| **2** | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 20 February 2023 I commenced an investigation into the death of Janet Kathleen SEDDON aged 79. The investigation concluded at the end of the inquest on 09 October 2024. The conclusion of the inquest was that: Janet Kathleen Seddon died as a consequence of naturally occurring disease contributed to by a delay in correctly identifying her abdominal pathology. |
| **4** | **CIRCUMSTANCES OF THE DEATH**<br><br>On the 30th of January 2023 Janet Kathleen Seddon underwent a CT scan of her abdomen and pelvis at York District Hospital to investigate abdominal symptoms, which was reported as showing a sigmoid stricture containing a presumed faecalith. On the 7th of February 2023 the same CT scan images were re-reviewed and reported as showing a fistula between the gallbladder and duodenum containing an impacted gallstone and indicating impending obstruction of the bowel. Mrs Seddon was surgically assessed at the hospital the same day and consented to an emergency laparotomy. While Mrs Seddon was stable in the immediate post-operative period, her condition steadily deteriorated with signs of developing sepsis. Despite intensive care she died at the hospital on the 9th of February 2023. |
| **5** | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows:<br>(brief summary of matters of concern)<br><br>1. The Trust became aware on the 7th of February 2023 that abdominal pathology requiring urgent assessment had been missed when Mrs Seddon's CT scan was initially reported on the 30th of January 2023. I found at inquest that there had been significant progression of Mrs Seddon's bowel obstruction in the period between the initial report and the subsequent review, and that the delay in identifying her condition more than minimally contributed to her death. |

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| | 2. The Trust referred Mrs Seddon's death to the Coroner on the basis that her family was concerned about possible omissions in primary care. Despite the Trust becoming aware of the missed pathology on the 7th of February 2023, it does not appear to have set in motion any process of investigation of the case until approximately September 2023. I was advised that a radiology candour panel concluded in October 2023 that there had been a reporting error and that a reasonable body of radiologists would have identified the concerning pathology on the CT scan. This finding was referred to the clinical care group responsible for Mrs Seddon's care for them to assess whether the error had caused harm to Mrs Seddon, but no such definitive assessment took place and the Trust closed the investigation. As a result, no disclosure was made to Mrs Seddon's family of the error in accordance with the Trust's statutory Duty of Candour. The report of the closed investigation, indicating that an error had occurred in the reporting of the scan but no assessment of harm had been made, was not received by the court until February 2024, more than a year after Mrs Seddon's death.<br><br>3. My concerns relate to –<br><br>a) the very significant delay in addressing whether the missed abdominal pathology was the result of a reporting error;<br>b) the absence of any proper assessment of harm caused to Mrs Seddon as a result of the error;<br>c) the delay in clear disclosure of the error to Mrs Seddon's family and to the Coroner;<br>d) the absence of evidence that all relevant learning arising from the above has occurred and any actions arising from such learning have been completed;<br>e) the potential risk of death to others in the event of a recurrence of any of the above. |
| **6** | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by December 09, 2024. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons<br><br>[redacted]<br><br>I have also sent it to<br><br>**Department of Health & Social Care - Prevention of Future Death Reporting**<br><br>who may find it useful or of interest.<br><br>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.<br><br>I may also send a copy of your response to any person who I believe may find it useful or |

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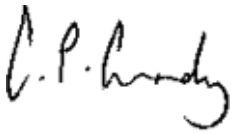
| | of interest.<br><br>The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest.<br><br>You may make representations to me, the coroner, at the time of your response about the release or the publication of your response by the Chief Coroner. |
| **9** | **Dated: 14/10/2024**<br><br>  <br><br>**Catherine CUNDY**<br>**Area Coroner for**<br>**North Yorkshire and York** |