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:** Department of Health & Social Care 39 Victoria Street London SW1H 0EU By Email only to :- [redacted]
1	**CORONER** I am Mrs D HOCKING, His Majesty's Assistant Coroner for the coroner area of Leicester City and South Leicestershire.
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 29 May 2024 I commenced an investigation into the death of Karen Pamela DACK aged 43. The investigation concluded at the end of the inquest on . The conclusion of the inquest was that: The cause of death was established as: I a Sepsis I b Spontaneous Bowel Perforation I c Sigmoid Diverticular Stricture II
4	**CIRCUMSTANCES OF THE DEATH** Ms Dack had worsening symptoms of stricture and obstruction of the bowel. She had a colonoscopy on the 21 December 2023 which showed a stricture of the bowel. In April 2024, following admission via the emergency department, planned urgent surgery did not happen because there were no intensive care beds and her condition had appeared to have resolved. She was fast tracked to have an elective bowel resection on the 17 May 2024. On the 02 May 2024, following another emergency

	admission she again had urgent surgery planned but it did not go ahead due to her surgery being superseded by other more urgent cases. Her treating consultant told this inquest that it was his plan to take Karen back to theatre the next day but this was not clearly communicated and Karen was discharged with the elective surgery still to take place as previously planned on the 17 May 2024, which was the plan written in the electronic records. There was no assessment by any senior surgeon as to Karen's fitness to be discharged and there was confusion about the management plan by the nurses on the ward. Karen re-presented to the emergency department four days later with worsening abdominal pain, vomiting and diarrhoea. She had not suffered a perforated bowel at the time of admission, but the plan was that she should be taken to theatre for a laparoscopic bowel resection the following day. Due to the volume of operations at this time this did not take place on the 07 May and was planned for the next day. It is clear from the evidence that Karen's condition deteriorated suddenly on the morning of the 08 May 2024, most likely due to perforation of her bowel. Once this was recognised surgery was completed urgently but Karen did not recover and became septic and sadly died despite the surgeons attempts to save her with several further operations. The evidence heard is that had Karen had any of the planned operations before her bowel perforated on the 08 May she would have survived.
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) That this lady's surgery was cancelled at the last minute on three separate occasions due to lack of theatre availability. I heard from the Deputy Clinical Director at Leicester Royal Infirmary that there has been a review of how patients are prioritised and whether they are effectively using their emergency theatre capacity. He said that 'the obvious problem with emergencies is they are unpredictable, there are times when the emergency list only requires one theatre and there are times when there are so many cases on the emergency list that we need to cancel elective cases in order to accommodate them and SOPs are in place around this.' He went on to say that there were no imminent plans for theatre expansion at the University Hospitals of Leicester (UHL) and that the categorisation and access to emergency theatres are probably as good as they can get with the currently available resources. I am concerned that whilst UHL is doing its utmost to deal with this problem the fact is that regardless of how patients are categorised there are still the same number of theatres available and that this issue will happen again, and further deaths may occur.
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 January 31, 2025. 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: 1) The deceased's family 2) University Hospitals of Leicester 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: 10/12/2024**  **Mrs D HOCKING** **His Majesty's Assistant Coroner for Leicester City and South Leicestershire**