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 NHS England** **2 The Royal College of Radiologists**
1	**CORONER** I am Steve ECCLESTON, Assistant Coroner for the coroner area of West Yorkshire Western Coroner Area
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 27.03.24 I commenced an investigation into the death of «Gemma Suzanne Marshall (Female) (DoB 27.07.22) aged 46. Ms Marshall died on 15.03.24 at Huddersfield Royal Infirmary. The investigation concluded at the end of the inquest on 18.12.24. The conclusion of the inquest was in narrative form: **Gemma Marshall died on 15.03.24 at the Huddersfield Royal Infirmary from the consequences of her gastric band slipping and causing her stomach to twist and suffer a haemorrhagic infarction. The infarction caused a build-up of blood-stained fluid in her peritoneum which stimulated her vagus nerve which then caused an arrhythmia in her heart. She then collapsed in the shower and could not be resuscitated. An outsourced CT scan failed to advise that the gastric band had slipped and this contributed to a failure to refer Gemma to bariatric specialists who could have intervened such that she might have lived. This failure represents neglect in the care that Gemma received.**
4	**CIRCUMSTANCES OF THE DEATH** Ms Marshall had private surgery for the fitting of a gastric band on 17.11.20. On 13.03.24 she attended the hospital with black vomiting and lower abdominal pain. She collapsed in the shower in hospital on 15.03.24 and did not recover. A postmortem found that the gastric band had "slipped" and that this was a causative factor in her death.
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) Evidence was given by the consultant surgeon who fitted the band, a senior bariatric surgeon at the treating hospital and a consultant radiologist at the treating hospital that the gastric band had slipped.

	A CT scan was undertaken on 13.03.24 and reported on by a radiologist with expertise in musculoskeletal imaging (rather than gastric or abdominal imaging) who worked for an outsourced company. This was because of staff shortages in the hospital. The scan report mentioned the existence of the band but didn't comment on the fact that the images clearly showed the band was out of position. That is that the stomach had slipped and had formed a pouch above the band. This was, in my view, a critical failure in the care Ms Marshall received. Had this image been correctly reported, then a referral to bariatric surgeons would have probably been made which might have meant she would have survived. Evidence from the consultant radiologist and the consultant surgeon in the hospital was that this failure to report that the band had slipped was because of a lack of familiarity in radiologists as to how slipped bands present, something which was compounded by 1. The increasing rarity of the procedure, 2. The consequences of specialisms which are not familiar with the abdomen or bariatric issues and 3. A need to sometimes rely on outsourced third-party radiologists without the relevant specialism because of staff shortage. While the hospital had taken steps to address this knowledge gap, there remained a concern that this lack of knowledge as to how slipped bands present was an issue of concern across the country and that other patients could face similar failures to Marshall.
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 February 17, 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 [redacted] **Calderdale and Huddersfield NHS Foundation Trust** I have also sent it to [redacted] **(Trust Legal Representative)** 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: 02/01/2025**  **Steve ECCLESTON** **Assistant Coroner for** **West Yorkshire Western Coroner Area**