REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive of Mid & South Essex NHS Trust**
1	**CORONER** I am Sonia Hayes, Area Coroner, for the coroner area of Essex
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 17 March 2023, I commenced an investigation into the death of Lady Lola Kay CROUCH, AGE 80. The investigation concluded at the end of the inquest on 30 January 2025. The conclusion of the inquest was 1a Multi-Organ Failure 1b Small Bowel Obstruction 1c Leiomyosarcoma of Small Intestine (operated) and Abdominal Adhesions following Hysterectomy 2 Chronic Obstructive Pulmonary Disease A combination of malignancy and adhesions caused small bowel obstruction. Lady Lola was a high risk of developing adhesions due her historical abdominal procedures. An inpatient CT scan in December 2022 showed potential malignancy was not followed up.
4	**CIRCUMSTANCES OF THE DEATH** Lady Lola Kay Crouch had a history of hysterectomy and laparotomies and died at Broomfield Hospital on 26 February 2023 of Multi-Organ Failure due to Small Bowel Obstruction caused by Leiomyosarcoma of Small Intestine (operated) and Abdominal Adhesions following Hysterectomy in a background of Chronic Obstructive Pulmonary Disease. A CT Scan in December 2022 showed small bowel obstruction with suspicion for a mass lesion that was not followed up. Lady Lola was treated for vomiting and abdominal pain on attendance to hospital overnight and sent home on 23 February 2023. Lady Lola reattended approximately 10 hours later with worsening symptoms and nasogastric tube was inserted approximately 6 hours after directed. A CT Scan confirmed

	malignancy at the same site as the original scan. Lady Lola deteriorated with vomiting and metabolic derangement that required emergency laparotomy with bowel resection and histology confirmed localised Leiomyosarcoma of the small intestine.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – (1) Lady Lola was not informed of the findings of potential malignancy from a CT scan in December 2022. This was not followed up and was then not given as part of the history when Lady Lola attended hospital in February 2023. (2) Staffing levels – A Medical Emergency call was not triggered overnight on the surgical ward when elevated NEWS scores required medical review that was escalated but delayed due to doctor staffing levels.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 16 April 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: • Family I have also sent it to Care Quality Commission who may find it useful or of interest. The Chief Coroner may publish either or both in a complete or redacted or summary form. She 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	 **21 February 2025** **HM Area Coroner for Essex Sonia Hayes**