REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Secretary of State Department of Health and Social Care.** **The British Society of Gastroenterology**
1	**CORONER** I am Nigel Parsley, Senior Coroner, for the coroner area of Suffolk.
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 5th June 2024 I commenced an investigation into the death of **Thomas Alexander GLOVER** The investigation concluded at the end of the inquest on 10th March 2025. The conclusion of the inquest was that the death was the result of:- **Naturally occurring strangulation of a hiatus hernia with delayed surgical intervention resulting from an earlier missed opportunity for earlier diagnosis.** The medical cause of death was confirmed as: **1a Multi-organ Failure** **1b Strangulated Hiatus Hernia and Ischaemic Stomach**
4	**CIRCUMSTANCES OF THE DEATH** **Thomas Glover's death was recognised at 21:00 on 22nd May 2024, at the Bloomfield Hospital, Chelmsford, in Essex.** **Tom had been transferred from the Ipswich Hospital to the Broomfield Hospital on the 16th April 2024, following the delayed presentation of a strangulated hiatus hernia with an ischaemic stomach.** **Tom underwent a number of emergency surgeries at the Broomfield Hospital, which were ultimately unsuccessful. Tom developed multi-organ failure, and was commenced on end-of-life care until his death on the 22nd May 2024.** **On the 13th April 2024 Tom had attended the Ipswich Hospital with vomiting symptoms indicative of a gastroenteritis, an inflammation of the stomach and intestines. Tom was admitted onto an assessment unit for observations overnight.** **On the 14th April 2024 Tom was reviewed by a Doctor at around 11:00, and was deemed to be clinically well enough for discharge. Tom was discharged at around 17:00 on the 14th April 2024.**

	On the afternoon of 15th April 2024 Tom became acutely unwell and returned to the Ipswich Hospital, where he suffered a cardiac arrest. Once resuscitated he was diagnosed with a strangulated hiatus hernia and transferred by blue light ambulance to Broomfield Hospital. **Despite intensive care unit support and emergency surgeries, Tom had suffered irreversible damage to his gastrointestinal system, from which he could not survive.** **Prior to his discharge on the 14th April 2024, Tom had continued to vomit and looked unwell, but this information was not escalated to the discharging clinician. Had this information been escalated, it is more likely than not that Tom would have not been discharged.** **Tom's discharge on the 14th April 2024 led to a missed opportunity to diagnose Tom's strangulated hiatus hernia at the time it developed, delaying any subsequent treatment.** **Whether or not an earlier diagnose of Tom's strangulated hiatus hernia would have prevented the tragic outcome, could not be established on the available evidence.**
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters given 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** as follows. – 1. **At inquest it was heard in evidence Tom was suffering from a hiatus hernia, which is a common condition suffered by up to 60% of the population in middle and later life. In the majority of cases a hiatus hernia is asymptomatic, and an individual can be unaware of its presence.** **Evidence identified there are two types of hiatus hernia.** a) **A sliding hiatus hernia, which moves up and down through the naturally occurring hole in the diaphragm, and therefore in and out of the chest area, and;** b) **A para-oesophageal hiatus hernia (also called a rolling hiatus hernia) where part of the stomach pushes up through the hole in the diaphragm next to the oesophagus and stays there.** **In the population over 80% of those individuals who suffer from this condition have a sliding hiatus hernia, whilst only between 5-15% will have a para-oesophageal hiatus hernia.** **The difference between the two types of hiatus hernia is import, as the para-oesophageal hiatus hernia is far more likely to develop known complications, and therefore more likely to require surgery.**

	2. **However, it was heard in evidence that in England many non-gastro specialist medical clinicians within the NHS are unaware of the difference in the two types of hiatus hernia, and are therefore unaware of the additional risk posed to the 5-15% of patients with a para-oesophageal hiatus hernia.** 3. **It was heard in evidence that the NHS England online guidance makes no distinction between the two types of hiatus hernias, whereas the guidance for NHS Scotland does.** 4. **As a result, the lack of understanding of the difference between the two types of hiatus hernia within the medical community means that there is no increased vigilance taken when individuals with a para-oesophageal hiatus hernia present with symptoms.** 5. **In addition, the cohort of individuals who suffer from para-oesophageal hiatus hernia in England, are unaware of the increased risk posed by their condition and are therefore unable to advocate for more testing, or seek a second opinion when worrying symptoms do arise.**
	ACTION SHOULD BE TAKEN In my opinion action should be taken in order to prevent future deaths, and I believe you or your organisation have the power to take any such action you identify.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely 19th May 2025 I, the Senior Coroner, may extend the period if I consider it reasonable to do so. 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 other Interested Persons in this matter I am under a duty to send the Chief Coroner a copy of your response. 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 she believes may find it useful or of interest. You may make representations to me, the Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**24th March 2025**  **Nigel Parsley**