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 [redacted], Chief Executive of Royal Berkshire NHS Foundation Trust**
1	**CORONER** I am Mrs H J Connor, Senior Coroner for the coroner area of Berkshire.
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. It is important to note the case of *R (Dr Siddiqui and Dr Paeprer-Rohricht) v Assistant Coroner for East London*. This case clarifies that the issuing and receipt of a Regulation 28 report entails no more than the coroner bringing some information regarding a public safety concern to the attention of the recipient. The report is not punitive in nature and engages no civil or criminal right or obligation on the part of the recipient, other than the obligation to respond to the report in writing within 56 days.
3	**INVESTIGATION and INQUEST** The family requested me to refer to the deceased as Lorraine. I will reflect that in this report. I conducted an inquest into the death of Lorraine Sandra Parker which concluded on 3rd April 2025. She was 52, and died on 30th March 2024. I recorded a narrative conclusion as follows: Natural causes, contributed to by cancer, by necessary surgical treatment, and by delay in diagnosing and managing anastomotic leak, after surgery conducted on 23rd of January 2024.
4	**CIRCUMSTANCES OF THE DEATH** Lorraine Parker's death was the third in three months following surgery by the same consultant colorectal surgeon. I have raised concerns in that respect separately. The surgeon in question is no longer conducting major surgery at your trust or in the local private sector. I am not aware of any current GMC restriction on his clinical practice. • With the permission of both families, I referred to two previous inquests - Mr MR (date of death 4th March 2024), and Mr ME (date of death 28th December 2023). I did this not to re-open the facts of the two earlier inquests, but to focus on the trust's death investigation processes, and how efficient they have been in terms of picking up issues following each of these deaths. • I instructed independent colorectal surgery experts to comment on the management, using two different experts for the three cases. It is fair to say that both experts were critical of the surgeon's management. In looking at the trust's death investigation processes, I made the following findings: • In the case of Mr ME, a significant surgical error was made when a healthy part of the bowel was removed instead of the area with the cancer, resulting in a much more

	extensive operation and Mr ME dying around 5 weeks later. This was discussed in a morbidity and mortality meeting, which ends with the simple phrase "await coroner's report". A structured judgment review was carried out by a consultant colorectal colleague on 4th of May 2024, over four months after the death. According to this review, all of the care given to Mr ME was either "good" or "excellent". • A further structured judgement review took place. It would appear that none of the colorectal surgeons was willing to carry this out, resulting in the need for a gastroenterologist to conduct a second review in July 2024, by which time the surgeon had already been suspended from major operative work. • It is important to note that in a clinical governance meeting in February 2024 (ie before either of these structured judgement reviews) it was noted that there were "no learning points identified" in relation to Mr ME's case. • In the case of Mr MR, a structured judgement review took place conducted by a consultant surgical colleague. This report was frankly so poor that I wrote to the Chief Medical Officer about it after the inquest. It has the look of the briefest of reviews and tick box exercises. Again, all of the management is referred to as "good". • Mr MR's case was not discussed during the March 2024 morbidity and mortality meeting, despite the fact that a later death (Lorraine Parker's, on 30th March 2024) was discussed then. Mr MR's case did not go to a morbidity and mortality meeting discussion until May 2024. The reasons for this remain unclear. • In Lorraine's case, there was a morbidity and mortality meeting discussion in March 2024 (or perhaps shortly thereafter). The April clinical governance meeting minutes refer to Lorraine's case and again state "no learning points". • None of these three cases has been the subject of a detailed PSIRF report. I have set out my concerns about the Trust's death investigation processes in more detail below. It is important to mention that I have found it far too difficult to extract the relevant documents from the trust in each of these cases. To expand on this: • During Lorraine's inquest, I received for the first time, a death investigation document relevant to Mr MR's case (an inquest I conducted in October 2024). • This difficulty extends routinely to obtaining medical records from this trust. This is not an issue which is shared with other trusts we work with within Berkshire. • RBH now has electronic records, and it is difficult for me to understand how it is that so many inquests I have conducted recently have had incomplete records. Provision of records found at short notice is rapidly becoming the norm. This is unhelpful to me and it is unhelpful to the bereaved families we deal with. It also means that death investigation processes are hampered and risk being incomplete. • This approach appears to apply to the clinical governance documents I have requested in each of these cases as well. I cannot be sure in any case whether I have received all of the relevant documents or not. I have not formed the view that this is due to a lack of candour, but whatever the reason, it is surprisingly inefficient for a trust of this size.
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) 1. On the evidence I have seen from the three inquests referred to, the Royal Berkshire Hospital's death investigation process is not working well. 2. I have seen evidence of delayed morbidity and mortality meetings with no clear system for ensuring that these discussions happen timeously. 3. There is little (if any) record of areas of concern identified at meetings – whether at morbidity and mortality meetings or clinical governance meetings. 4. There is delayed escalation of concerns. 5. Structured judgement reviews I have reviewed are at best, poor, and at worst, defensive. 6. Delayed or no scrutiny of cases being reported to the coroner because the cause of death is unnatural, given that medical examiners are not funded to scrutinise those cases. Opportunities for early learning are therefore being lost. 7. Systems of collating and providing medical records and clinical governance records to the coroner (and presumably to others involved in death investigation) are unreliable. 8. I am concerned about whether the trust has done enough to deal with the concerns about this particular surgeon, not just in the Berkshire area, but more widely.
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 June 19th, 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 Lorraine's family. I have also sent this report to the following recipients, who may have an interest in this matter: 1. Family of Mr MR. 2. Family of Mr ME. 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. 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 coroner, at the time of your response about the release or the publication of your response by the Chief Coroner.
9	**Dated 23/04/2025**  **Heidi Connor**

	Senior Coroner for Berkshire