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], President of the Association of Coloproctology of Great Britian.** **2 [redacted], National Director of Patient Safety and Deputy Chief Medical Officer at the Department of Health and Social Care.** **3 [redacted], acting CEO of the Royal College of Surgeons.**
1	**CORONER** I am HEIDI J CONNOR, Senior Coroner for Berkshire 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** This can be summarised by my findings on the Record of Inquest as follows: Lorraine Parker had an operation for sigmoid colon cancer on 23rd of January 2024. Although there was some improvement in the patient's clinical condition, there was a delay in investigating clinical signs and blood markers, specifically CRP results, from 27th of January 2024. Lorraine was discharged home on 31st of January 2024 with no post-operative scan and a CRP of 173. The CRP result had been increasing over the past three days before her discharge. On return to hospital on the 1st of February, her CRP had continued to rise and a CT scan was carried out. The scan was misreported as showing no anastomotic leak. It was only when faeces began to leak from her wound that the scan was re-reviewed and noted to show anastomotic leak. She was initially managed conservatively, but was then returned to theatre. Her descending colon was noted to be disintegrated.

	Lorraine was managed on the intensive care unit between 5th and 14th of February, and on a ward thereafter before being discharged home on 23rd of February. She was re-admitted to hospital between 12th and 15th of March, when a drain was inserted to remove a pelvic collection. When attending a routine wound review appointment on 30th of March 2024, Lorraine became suddenly unwell. The crash team attended and resuscitation efforts were carried out, but she died that day, at Royal Berkshire Hospital, Reading in Berkshire. Her cause of death was: 1a Pulmonary embolism 1b Deep Vein Thrombosis 2 Sigmoid colon adenocarcinoma (operated January 2024) I concluded that delay in diagnosing and managing anastomotic leak contributed to 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) 1. It is clearly the case that clinical judgment is the most important factor in deciding when a patient who has undergone major abdominal surgery requires a CT scan. Surgeons will "treat the patient, not the numbers". 2. There is currently no guidance which requires surgeons to consider scanning for patients who have undergone major abdominal surgery and whose CRP is high and not decreasing, as was the case here at the time Lorraine was discharged from hospital on 31st January 2024. 3. There may be some difficulty in creating a hard line requirement for CT scanning based on a particular CRP result, but I am concerned that there is no guidance in place for requiring a consultant to consider this – perhaps when the CRP is above a certain figure and either not decreasing or continuing to rise. Any such guidance could still allow for clinical judgement – and documenting of the reasons for that decision. 4. It is my experience that clinical judgement alone, particularly where a patient looks well "from the end of the bed" is not always sufficient in this scenario. I have seen a number of avoidable death cases in this context. The purpose of blood test results is to flag up objective areas of concern. There is much reference to chasing up CRP results in Lorraine's records, but these do not appear to have been taken into account at the time that she was discharged from the hospital without a post-operative scan.
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. Legal representative for Royal Berkshire NHS Foundation Trust. 2. [redacted], consultant colorectal surgeon (who acted as independent expert in this case). For the avoidance of doubt, the 2 recipients referred to in this paragraph have been copied in out of interest and are not expected to send a formal response. I am also under a duty to send the Chief Coroner a copy of the response of the three recipients mentioned at the top of this letter. 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 J CONNOR** **Senior Coroner for Berkshire for Berkshire**