REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

IN THE MATTER OF THE INQUEST

TOUCHING THE DEATH OF

DAVID ARTHUR SHARP BATEMAN

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **Interim Chief Executive** **NHS University Hospitals Trust Plymouth**
1	**CORONER** **I am Guy Davies, His Majesty's Assistant Coroner for Cornwall & the Isles of Scilly.**
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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 30 July 2024 I commenced an investigation into the death of 76-year-old David Arthur Sharp BATEMAN, known as Dave to family and friends. The investigation concluded at the end of the inquest on 15 May 2025. The medical cause of death was found as follows *1a Frailty Syndrome* *1b Progressive Deconditioning following Recurrent Admissions for Pelvic*

	Collections *1c Laparoscopic Pan Proctocolectomy and Ileostomy (3/9/2023)* The four questions - who, when, where and how – were answered as follows … *David Arthur Sharp BATEMAN died on 22 July 2024 at Pengover House Care Home Liskeard Cornwall from recognised complications following an elective operation, namely a Laparoscopic Pan Proctocolectomy and Ileostomy performed at University Hospital Plymouth on 3 September 2023.* The conclusion of the inquest was as follows *David Arthur Sharp BATEMAN died as a result of recognised complications of an elective operation.*
4	**CIRCUMSTANCES OF THE DEATH** Dave opted for an elective surgical procedure due to high-risk cancerous colon polyps which had developed following a lengthy period of ulcerative colitis. The surgery was performed on 3 September 2023 at Derriford University Hospital Plymouth (UHP) and was uneventful. However, following that initial procedure, Dave suffered significant post operative complications which required multiple admissions to Derriford and interventions/treatments for a pelvic collection and urethral injury. Dave had a final operation to try and deal with these complications on 24 December 2023. It was found that before the operation on 3 September 2023 that Dave was fit, active and relatively healthy. However, by 24 December 2023 Dave had physically deconditioned and developed significant cognitive impairment. It was found that Dave's deconditioning led to the development of dementia such that he was no longer able to care for himself and had entered a period of irreversible decline after the final operation on 24 December 2023, that led to his death from frailty syndrome on 22 July 2024. The court found evidence of poor nursing care on Derriford UHP Wolf Ward, particularly during the immediate post-operative period, from 3 September to 24 December. The poor nursing care contributed to Dave's deconditioning in the following: • Ineffective support for taking nutrition, leading to significant weight loss. The medical records indicated that Dave's weight dropped from 86 kilos on 7.9.23, down to 64.8 kilos on 2 Dec 2023, amounting to

	approximately 25% weight loss • Insufficient monitoring of weight • Inadequate physiotherapy • Repeatedly found to be lying in a soiled bed • Frequently in an unwashed condition • Frequently with a split stoma bag The court found on the basis of evidence from the hospital's treating consultant that this poor care and treatment from September to December 2023 amounted to a missed opportunity to rehabilitate Dave following the operation. The treating consultant stated that such poor care raised a mortality risk for other patients. There were three witnesses from UHP giving evidence before the court, a consultant and two nursing witnesses. They were unable to assist the court upon whether these issues of poor care have been addressed.
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. The finding of poor nursing care and treatment that was possibly causative of Dave's death and the evidence of the treating consultant that such poor care raised a mortality risk for other patients. 2. There was no evidence before the court that these concerns have been addressed and remedied.
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 17 July 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 family. I am also 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. 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	**21 May 2025** **HMC Guy Davies**