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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. NHS England
1	**CORONER** I am Andrew Cox, the Senior Coroner for the coroner area of Cornwall and 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.
3	**INVESTIGATION and INQUEST** On 30/4/25, I concluded the inquest into the death of John Stephen England who died in Royal Cornwall Hospital on 15/3/23. I recorded the cause of death as: 1a) Aspiration; 1b) Ileus; 1c) Sigmoid volvulus (operated 12/3/23) II) Transient ischaemic attack; hypertension I recorded a Narrative conclusion that Mr England died from natural causes. It is more likely than not that the delays in conveyance to hospital and in definitive medical intervention contributed to the development of a post operative ileus and Mr England's death more than minimally.
4	**CIRCUMSTANCES OF THE DEATH** Mr England lived in Gloucester. In 2018, a CT at Gloucester Royal Hospital revealed he had a very long redundant sigmoid loop which it was recognised left him very prone to a volvulus. Between February 2020 and February 2023, he had five separate presentations to hospital with a sigmoid volvulus, four of which required medical intervention to resolve. In March 2023, Mr England came to Cornwall on holiday. In the early hours of 12/3/23, he developed abdominal pain with increasing

	distention. He rang for an ambulance at 01:37 reporting to the call handler that he suspected he had a twisted bowel. Owing to operational pressures, there was delay in the arrival of an ambulance. Mr England arrived at Royal Cornwall Hospital at 08:05. There was delay transferring Mr England from the ambulance and into hospital. An x-ray and CT scan were performed. Both supported a diagnosis of sigmoid volvulus. The CT scan was reported at 10:48 but not brought to the attention of the locum consultant surgeon until approximately 15:30. A rigid sigmoidoscopy was performed at approximately 16:00 but due to concerns over the appearance of the bowel and whether it was ischaemic, a flexible sigmoidoscopy was performed at approximately 18:00 which confirmed ischaemic/infarcted tissue. A laparotomy was performed at approximately 20:30 when a gangrenous section of bowel was removed and a stoma formed. At a ward round on 15/3/23, Mr England was found to be short of breath and with a distended abdomen. A post-operative ileus was diagnosed and a direction given for a naso-gastric tube to be placed. During the course of its placement, Mr England became distressed and suffered an acute collapse. He could not be resuscitated and died in Royal Cornwall Hospital on 15/3/23.
5	**CORONER'S CONCERNS** During the course of the inquest, the evidence has 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) At the time of the initial call to South West Ambulance Service Trust, Mr England reported that he thought he had a 'twisted bowel.' This had happened to him on five previous occasions in Gloucester when medical intervention had been required four times to decompress a sigmoid volvulus. The call handler, using the MDPS system, reached a Category 5 disposition. Two experts who gave evidence at inquest, [redacted], a Consultant Surgeon, and [redacted], a Consultant Gastroenterologist, both felt Mr England needed to be conveyed to hospital within two hours which I believe would have required a Category 3 disposition. As both the fact of a delay and its causative relevance were admitted by the Trust, the detail of the call and the questions asked to reach a disposition were not enquired into at inquest. Evidence was heard, however, that upon audit it was felt the call handler had achieved a high degree of compliance with expected standards. This raises a concern whether the system is sufficiently nuanced to distinguish between different types of abdominal complaints and to

	ensure that those who need to be recognised as a surgical emergency receive a disposition resulting in a patient being conveyed to hospital within an appropriate timeframe.
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 6 July. 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: - The family of Mr England; - South West Ambulance Service Trust; - Royal Cornwall Hospital 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	**[DATE]** **[SIGNED BY CORONER]** **9.5.25**