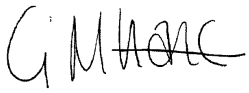
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 PSIR - York & Scarborough NHS Trust**
1	**CORONER** I am Gillian KANE, Assistant Coroner for the coroner area of North Yorkshire and York
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 29 September 2023 I commenced an investigation into the death of Joanne Louise STONES aged 53. The investigation concluded at the end of the inquest on 14 July 2025. The conclusion of the inquest was that: Joanne Louise Stones died on the 17th of September 2023 at Scarborough Hospital, Woodlands Drive, Scarborough, North Yorkshire, YO12 6QL, after being admitted for abdominal pain and ultimately being diagnosed with acute cholecystitis with gallstones against a background of Anti-Phospholipid Syndrome and Addison's Disease.
4	**CIRCUMSTANCES OF THE DEATH** Joanne Louise Stones ('Joanne') was a 53-year-old lady with a complex medical history. Joanne had a medical condition called Anti Phospholipid Syndrome [APS]. In 2021 Joanne experienced Catastrophic Antiphospholipid Syndrome (APS) which led to Addison's Disease (AD). As a result of this Joanne's body could not produce cortisol and she required lifelong steroid treatment with Hydrocortisone. If Joanne had an infection, she needed her hydrocortisone level to be recalibrated to manage it. On the 10th of September 2023, Joanne was taken by ambulance to hospital where she was given a provisional diagnosis of suspected gallstones and discharged home with oral antibiotics and analgesia. Her medical notes showed that those treating her were aware that her medical history included the diagnoses of APS and AD. On the 13th of September 2023, Joanne attended the hospital again for a planned ultrasound and was diagnosed with Acute Cholecystitis with gallstones. She was discharged home and advised to complete the course of antibiotics she had previously been given. On the 16th of September 2023, Joanne was 'blue lighted' to hospital with suspected Cholecystitis. The hospital was 'pre-alerted' ahead of her arrival as paramedics were concerned about her condition. Joanne was received into the First Assessment Area and there was a delay of over 2 hours before she was moved to Resus. There was a delay in administering intravenous antibiotics and fluids leading to Joanne developing hypoglycaemia. There was substantial delay before it was recognised that Joanne had AD and she required steroids. Joanne's condition deteriorated rapidly and she was transferred to intensive care where she

	died on the 17th of September 2023. I found during the course of the inquest that there were delays in recognising and appropriately treating Joanne's condition. I was unable to determine on the balance of probabilities that these caused or more than minimally contributed to her death. However, there was evidence of omissions and delays in the treatment that Joanne received which caused me concern.
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) The ambulance service pre-alerted the hospital regarding Joanne's serious condition but this did not result in her being prioritised and placed in Resus on arrival. Joanne was wearing two medic alert bracelets to draw attention to her diagnoses of APS and AD but these were not observed by the treating team. There were no visible 'red flags' on Joanne's medical records, highlighting her APS and AD diagnoses to the treating team. The treating doctor relied on a very sick patient to confirm any underlying medical conditions. There was no liaison with Rheumatology, who had extensive knowledge and experience of Joanne and how to treat her conditions. (2) There was delay in Joanne receiving fluids, which led to hypoglycaemia which was then not treated promptly. (3) It was not clear from the medical notes that staff treating Joanne had considered the relevance of her APS and AD in her treatment plan.
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 September 24, 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 following Interested Persons [redacted] I have also sent it to **DHSC** who may find it useful or of interest. 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. 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	**Dated: 30/07/2025**  **Gillian KANE** **Assistant Coroner for** **North Yorkshire and York**