REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Secretary of State for Health NHS England Stepping Hill Hospital
1	**CORONER** Christopher Murray HM Assistant Coroner Manchester South Coronial Area Mount Tabor Stockport
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 1st March 2024 an investigation was opened into the death of Neil John Clarke aged 81 years. The investigation concluded at the end of the inquest on 1st May 2025. Sitting without a jury I made a determination that Neil John Clark **died as a result of hypoxic encephalopathy, aspiration pneumonia and infarcted bowel arising as a consequence of aspiration secondary to vomiting which precipitated a cardiac arrest following a right hemicolectomy.**
4	**CIRCUMSTANCES OF THE DEATH** Neil Clarke was a fit 81 year old who was investigated by way of colonoscopy following reports of bowel discomfort. A colonoscopy and polypectomy were carried out on 12th December 2022. Two polyps were removed and were benign. A repeat colonoscopy on 29th August 2023 showed recurrence of a polyp in the caecum. Endoscopic mucosal resection polypectomy failed. A discussion in MDT took place and the consensus was to proceed with a right hemicolectomy. The options provided to Mr Clarke were conservative management, further polypectomy or a right hemicolectomy. The latter was advised as the most appropriate option by clinicians as it would involve one invasive procedure rather than two and provide clarity as to the nature of the

	polyps being cancerous or benign. The surgery carried out on 12th February 2024 at Stepping Hill Hospital was uneventful save for some post operative bleeding. Once stabilised he was transferred to ward D5 on 15th February 2024. He felt unwell that afternoon and vomited. His ward lights were turned out at 23:00 and he was made comfortable. At 02:00 on 16th February he was agitated and then violently vomited before suffering a cardiac arrest. CPR was administered and he was taken to the intensive care unit where he was treated and monitored. Sadly, he had suffered a hypoxic encephalopathy following aspiration secondary to vomiting. He went on to develop aspiration pneumonia and an infarcted bowel which in conjunction with his hypoxic encephalopathy resulted in his death at Stepping Hill Hospital on 26th February 2024.
5	**CORONER'S CONCERNS** The evidence heard during the inquest into Neil John Clarke's death and the findings confirmed there were a number of factors contributing to Neil's death which are of 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 - The considerations given to the appropriateness, from a safety and well-being perspective, of surgical procedures involving elderly patients who may benefit from more conservative measures and the associated documentation and guidance advising patients of different treatment choices. My second concern arising from this interest was the accuracy of hand over communications between clinical staff in respect of patients returning to the main ward from HDU.
6	**ACTION SHOULD BE TAKEN**

	In my opinion, action should be taken to prevent future deaths and I believe that 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 **27th August 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 following Neil's family. Care Quality Commission HHJ Alexia Durran, the Chief Coroner of England & Wales 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.
9	**DATE** 2nd July 2025 Signed *C S Murray* HM Assistant Coroner