REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Chief Executive, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust**
1	**CORONER** I am Dr Elizabeth Didcock, Assistant Coroner, for the coroner area of Nottinghamshire
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 8.5.24, I commenced an investigation into the death of 18/8/2025 The investigation concluded at the end of the inquest on the 28th July 2025 The conclusion of the inquest was a Narrative as follows: Emily had Crohn's disease, a serious inflammatory bowel condition that affected Emily's physical and mental health significantly. She had all necessary and appropriate treatment for this condition, but sadly required a sub-total colectomy and end ileostomy on 19.4.24, as her condition was not improving with full medical treatment. Whilst she was well enough post operatively for discharge on 24.4.24, she was not eating and drinking well. She then developed a steroid- induced psychosis, from necessary steroid treatment. On 27.4.24 she was admitted to Bassetlaw DGH with poor eating and drinking, generalised weakness, and confusion and agitation. A DOLS order was put in place on 30.4.24 Over this final admission she developed an ileus with sub-acute small bowel obstruction by 3.5.24, that was not recognised. She developed Acute Kidney Injury Stage 3 secondary to dehydration, which was not recognised. She developed aspiration pneumonitis from vomiting. The vomiting was not recognised to be indicative of an ileus with sub-acute bowel obstruction. This lack of recognition of her serious clinical deterioration by 3.5.24, led to a lack of necessary investigations, (that of repeat blood tests, and a CT scan of her abdomen), and therefore lack of necessary treatment of the dehydration and bowel issues present on that day. Emily further deteriorated over the 4th and 5th May with aspiration, evolving dehydration and acute kidney injury, and with untreated bowel blockage leading to continued vomiting, and to a cardiac arrest on the morning of 6.5.24. By this time she had severe aspiration pneumonitis and then developed multi organ failure from which she could not recover. Had necessary treatment for the bowel blockage and evolving dehydration, been provided on 3.5.24 as it should have been, on balance Emily would not have died on 6.5.24. Emily's death was contributed to by neglect

4	**CIRCUMSTANCES OF THE DEATH** Emily died on 6.5.24, at Bassetlaw DGH. During her final admission, following bowel surgery for Crohn's disease on 19.4.24, she had unrecognised dehydration leading to AKI stage 3 by the day of her death. She had unrecognised ileus and sub-acute small bowel obstruction, that led to bile stained vomiting over the four days prior to her collapse, and cardiac arrest on the morning of 6.5.24. The vomiting led to aspiration, and to aspiration pneumonitis, as Emily was in a weakened state from dehydration. Her weakened state was also caused by prolonged malnutrition, The malnutrition was secondary to her underlying disease process, that of Crohn's disease, the recent bowel surgery, and her prolonged poor oral intake. The following significant issues of care during her final admission, have made a more than minimal, negligible or trivial contribution to her death on balance. • The lack of assessment of fluid balance from admission on 28.4.24 onwards • The lack of adequate clinical assessment of hydration status from admission, but particularly from 2.5.24 onwards • The lack of accurate recording of vomiting, from 2.5.24 onwards • The lack of repeat blood teats from 2.5.24 onwards • The lack of recognition of the general deterioration in Emily's clinical state, with increasing weakness, and falls • The lack of consideration of likely physical causes for her confusion, and general presentation, that were evolving from admission onwards, but were clearly present from 3.5.24 onwards • The lack of a CT scan of her abdomen on 3.5.24 • The lack of attention and listening to the family concerns, raised throughout her admission but particularly from 2.5.24 onwards
5	**<u>CORONER'S CONCERNS</u>** 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. That patients on the wards at Bassetlaw DGH will have inadequate assessments of hydration status, and have inaccurate and inadequate completion of fluid balance charts 2. That nursing assessments, particularly in very vulnerable patients, will not identify a deteriorating patient, thus preventing necessary escalation for medical assessment 3. That there continues to be a risk that no clinical assessment will be undertaken, in patients attending the Emergency Department at Bassetlaw DGH, prior to referral for a mental health assessment , and that there continues to be a risk that no

	clinical assessment will occur in Emergency Department prior to a patients discharge home I am not reassured that necessary actions to address these serious issues identified are in place.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe you 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 the **13th October 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: 1. The family 2. The Nottinghamshire Healthcare NHS Foundation Trust 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	**18th August 2025** **Dr E. A. Didcock**