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REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: [redacted], Chief Executive, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

1. CORONER

I am Simon Tait Assistant Coroner for South Yorkshire East

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.

http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7

http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

3. INVESTIGATION and INQUEST

On 21 February 2025 I commenced an investigation into the death of John Bell. The investigation concluded at the end of the inquest . The conclusion of the inquest was a narrative conclusion that:

The deceased died as a result of recognised complications of a wound infection following appropriate spinal surgery. If the spinal surgeons had been aware of the prior diagnosis of a renal tumour, surgery to treat the renal tumour would have been prioritised and spinal surgery not undertaken at that time. This in turn would have avoided the spinal surgical wound infection and the deceased would not have died when he did.

The Medical Cause of death was:

1a Right upper lobe pneumonia

1b

1c

II Infected spinal surgery wound, ischaemic heart disease, localised left renal carcinoma

4. CIRCUMSTANCES OF THE DEATH

Mr Bell died at St John's Hospice Doncaster on 10 February 2025. His death was caused by right upper lobe pneumonia which was contributed to by an infected spinal surgery wound, ischaemic heart disease and localised left renal carcinoma.

On 25 October 2024 he underwent spinal surgery. At the time of that surgery, the spinal

surgeon was not aware that Mr Bell had recently been diagnosed with a renal tumour which required curative surgical treatment. If the spinal surgeon had been aware of that diagnosis, spinal surgery would not have been undertaken at this time and surgery on the renal tumour would have been prioritised.

Following the spinal surgery, Mr Bell was started on heparin to treat a renal thrombus which was a complication of the renal tumour. Heparin would not normally have been given following spinal surgery due to the increased risk of bleeding, however, the renal thrombus necessitated the administration of heparin in Mr Bell's case. The heparin in turn caused a wound haematoma which became infected. Despite treatment Mr Bell deteriorated and died on 10 February 2025 as a result of complications of the wound infection.

On the balance of probability, if the spinal surgery had been delayed to treat the renal tumour, Mr Bell would not have developed the haematoma and spinal wound infection and would not have died when he did.

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. Renal investigations were undertaken following a fast track cancer referral in September 2024. Investigations were undertaken and on 16 October 2024 a renal MDT reviewed CT scans and recommended that Mr Bell be considered for left nephrectomy to treat a renal tumour. Although the MDT note was apparently in the electronic records, the spinal surgeons were not aware of the renal findings at the time of the spinal surgery on 25 October 2024. Had they been aware, spinal surgery would not have been undertaken at this stage with the renal surgery being prioritised. I am concerned that critical clinical information was not available to and/or considered by, the spinal surgeons before the spinal surgery took place.

2. The issue in the previous paragraph came to light shortly after the spinal surgery in October 2024. However, no investigation of the incident was undertaken by the Trust. At the time of the inquest no Datix report had been submitted. The witnesses accepted at inquest that a Datix would have been good practice. I am concerned that some 8 months after the incident no formal investigation had taken place and no consideration of any learning had occurred.

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 **29th September 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 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.

4 August 2025

9

Signature

Simon Tait Assistant Coroner for South Yorkshire East