	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST**
1	**CORONER** I am Ana Samuel Assistant Coroner for Birmingham and Solihull
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 25 February 2025 I commenced an investigation into the death of Robert Tom Duke SIMPSON. The investigation concluded at the end of the inquest . The conclusion of the inquest was; Died as a result of complications suffered following necessary surgery contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** On the 4th June 2024 the Deceased, who had colonic cancer, underwent a hemicolectomy at Solihull Hospital. Following surgery, whilst on the ward, he developed hospital acquired pneumonia and an anastomotic leak. Despite a raised CRP and knowledge of a collection requiring drainage he was discharged home on the 28th June 2024 to await drainage. No antibiotics were provided on discharge and no appointment for drainage was booked. On the 1st July 2024 he was admitted to the Birmingham Heartlands Hospital as an emergency, having deteriorated whilst at home. Despite drainage of the collections and continued treatment he deteriorated, suffering from two peri-arrests. Death was certified at 21.40 on the 9th July 2024. Based on information from the Deceased's treating clinicians the medical cause of death was determined to be: 1a Hospital acquired pneumonia 1b 1c 1d II Bowel Cancer (operated), Intraabdominal collections/contained leak (drained with IR guidance), C Difficile Colitis, CoViD pneumonitis, Chronic Obstructive Pulmonary Disease, Arterial Hypertension
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. It was accepted by the Trust that the deceased had been provided and discharged with medication (gabapentin) that did not belong to him and had missed two doses of antibiotics (fidaxomin) due to the drug being out of stock, which had not been communicated to or escalated to treating clinicians. 2. In evidence the Trust were unable to confirm whether the issues set out in 1. above sat solely with the nursing team or also involved pharmacy. 3. Whilst evidence was given in relation to the discharge nurse having undertaken reflection and a focus group being set up to explore improvements with discharge and planning there was no evidence as to how the wrong medication was provided to the deceased and whether this was a discharge only issue or also an issue with allocation and distribution of medication by pharmacy or by ward staff. 4. There was no evidence to explain how the deceased missed two doses of antibiotics due to the drug being out of stock, why treating clinicians were not informed or why an alternative antibiotic was not administered in its place. The Trust were unable to talk to what, if any, systems were in place to ensure that patients were not left without necessary medication. 5. I am concerned that there may still be a risk to life of patients within the trust if they are provided with the wrong medication or miss necessary doses of prescribed medication.
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 7 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: The family of Mr Simpson I have also sent it to the Medical Examiner, ICS, NHS England, CQC, who may find it useful or of interest. 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. 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 by the Chief Coroner.
9	**12 August 2025**

	Signature: **Ana Samuel** **Assistant Coroner for Birmingham and Solihull**