



Regulation 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT DEATHS THIS REPORT IS BEING SENT TO: 1 The President of the British Society of Gastroenterology
1	CORONER I am Mr Paul Appleton, Assistant Coroner for the coroner area of Teesside and Hartlepool.
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 12 May 2025 I commenced an investigation into the death of Vivian Joan Tuddenham NOLAN, aged 84. The investigation concluded at the end of the inquest on 31 October 2025. I recorded the following narrative conclusion: Due to recognised complications arising from and following a diagnostic colonoscopy procedure.
4	CIRCUMSTANCES OF THE DEATH Vivian was referred to secondary care by her GP due to iron deficiency anaemia and a positive FIT test. Following review by the Gastroenterology Service, Vivian was listed for a diagnostic colonoscopy (the risks discussed as part of the consent process for the diagnostic colonoscopy included colonic perforation and need for emergency surgery). The diagnostic colonoscopy was performed on 31 March 2025 and following the colonoscopy, Vivian was diagnosed to have a colonic perforation. Despite medical and surgical treatment, Vivian deteriorated and sadly died on 10 May 2025. I recorded Vivian's medical cause of death to be the following: 1a) Hospital acquired pneumonia and Covid infection 1b) Colonic perforation 1c) Diagnostic colonoscopy procedure to investigate iron deficiency anaemia
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. During the course of the inquest hearing, I heard evidence from the Consultant Surgeon who performed the diagnostic colonoscopy. Their evidence included that, in their view, there ought to be a higher clinical threshold for offering diagnostic colonoscopies to patients aged over 80 given the associated, increased risks. Their



	evidence included that there is a higher clinical threshold in other countries for offering this diagnostic investigation to the 80+ age group. My concern is that there is a lack of knowledge amongst, and lack of clinical guidance available to, clinicians as to the potential increased risks of diagnostic colonoscopies in the 80+ age group.
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 December 30, 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. Vivian's Family. 2. South Tees Hospitals 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. 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	Dated: 05.11.2025 Mr Paul Appleton Assistant Coroner for Teesside and Hartlepool