REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1 [redacted], Chief Executive Officer, West Suffolk Hospital NHS Foundation Trust**
1	**CORONER** I am Darren STEWART OBE, HM Area Coroner for the coroner area of Suffolk
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 07 June 2024 I commenced an investigation into the death of **David ABBOTT** aged **72.** The investigation concluded at the end of the inquest on 06 March 2026. The conclusion of the inquest was: **Narrative Conclusion - David ABBOTT is remembered by his family as a 'gentle giant', kind, calm natured and devoted to his Family. Mr. ABBOTT was a 72-year-old man who enjoyed an active, healthy lifestyle prior to undergoing surgery on the 25th October 2023 at West Suffolk Hospital for a Transurethral Resection of his Prostate (TURP). In addition to an enlarged prostate his previous medical history included essential hypertension which was controlled through medication.** **Mr. ABBOTT had initially been scheduled for the TURP procedure in September 2023, however elevated blood pressure readings meant that this was rescheduled to the 25th October 2023 following adjustments to his medication which were successful in returning his blood pressure to within his target levels.** **The TURP procedure was successfully completed and Mr. ABBOTT was discharged the following day. Prior to his discharge, Mr. ABBOTT received advice 'that he should not have to put any pressure or weight bear'. Mr. ABBOTT interpreted this as meaning he should keep off his feet and not mobilise, something which is contraindicated for post-operative patients following a TURP procedure. There was no medical rationale recorded for this advice and it was not indicated by any condition recorded in Mr. ABBOTT's medical records. Nor was this advice included within the discharge documentation sent by the hospital to Mr. ABBOTT or his GP. Upon discharge, Venous Thromboembolism (VTE) Prophylaxis was not prescribed (it was not indicated) nor advice given in relation to the use of anti-embolism (TED) stockings.** **Following discharge, Mr. ABBOTT quickly developed discomfiture with breathing and experienced periods of back pain. This was initially likely to be due to a reaction to the general anaesthetic from the TURP procedure and an infection he contracted whilst in hospital. After the 30th October 2023, it is likely that small pulmonary emboli, which had propagated from Deep Vein Thrombosis (DVT) in his left or right calves, also contributed to these symptoms.**

	Between the 26th October and the 30th October 2023, Mr. ABBOTT acted on the discharge advice and did not mobilise, instead resting and keeping off his feet. It is likely that this contributed to him developing DVT in his lower legs. On the 30th October 2023 Mr. ABBOTT returned to hospital for an outpatient procedure to remove a catheter. This was performed without issue. **Mr. ABBOTT continued to experience breathlessness and general weakness giving rise to him calling his GP practice on the morning of the 29th November 2023 seeking a consultation with a GP. He was called back at 09.46 hours by a GP who proceeded to conduct a telephone consultation. The outcome of this consultation was a diagnosis of an infection, likely to be upper respiratory and for which antibiotics were prescribed. He was advised to contact 999 in the event that his condition worsened.** **At around 15.05 hours Mr. ABBOTT called 999 complaining of respiratory distress. Ambulance attended his residence at 15.18 hours where Mr. ABBOTT was found collapsed and in cardiac arrest. Resuscitation attempts were commenced, however these were unsuccessful and Mr. ABBOTT was pronounced deceased at the scene.** **A postmortem examination determined Mr. ABBOTT died from the effects of a Pulmonary Embolism, a naturally occurring condition. It is likely that shortly before 15.00 hours on the 29th November 2023, Mr. ABBOTT suffered a massive pulmonary embolism which led to his death.** The medical cause of death was confirmed as: **1a Pulmonary Embolism**
4	**CIRCUMSTANCES OF THE DEATH** **Narrative Conclusion see Part 4**
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 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: **West Suffolk Hospital NHS Foundation Trust** Evidence received from Mr. ABBOTT's Family at the Inquest was that advice provided to Mr. ABBOTT by a medical registrar at West Suffolk Hospital at the time of his discharge on the 26th October 2023 was to not weight bear and not be mobile. This is corroborated in the medical records where the relevant entry reads: 'avoid weight bearing'. In addition no advice was given in relation to the use of anti-embolism (TED) stockings. At Inquest, the clear evidence was that unless a medical rationale existed to the contrary, this advice was wrong. No medical rationale for the advice was recorded in Mr. ABBOTT's hospital notes, or in his discharge documentation. A possible explanation was offered that the registrar may have confused advice to 'avoid heavy lifting' with 'avoid weight bearing'. These are two very different forms of advice, the latter leaving Mr. ABBOTT with the clear and not unreasonable, impression that he was not to mobilise and avoid weight bearing following the procedure. He followed this advice until the 30th October 2023 when he attended a

	follow up outpatients clinic. Instead he should have mobilised and whilst not carrying heavy objects, otherwise carried on with his usual activity as far as possible.**,** By not mobilising and resting for this 4 day period, Mr. ABBOTT was more susceptable to contracting a DVT. This subsequently occurred and although it is not possible to establish precisely when the DVT/s formed, a period of 4 days of immobility immediately post operation will have likely contributed to him developing DVT in his lower legs. I am concerned that one or both of the following has occurred: a. The wrong advice has been provided to a patient on discharge which has exposed them to increased risk, and /or b. Inadequate record keeping has resulted in inaccurate records being maintained in relation to important advice provided to patients on discharge. If this is the scenario, there would appear to be no assurrance mechanism in place to identify and remedy any error. I am further concerned that the communication processes at West Suffolk Hospital between patients and hospital staff (including treating clinicians) are ineffective in affording patients and their families with adequate opportunity to engage with and inform clinical decisions around their care and treatment.
	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 May 28, 2026. 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. ABBOTT** **Unity Healthcare** I have also sent it to **Care Quality Commission** who may find it useful or of interest. 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 other 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.
9	**Dated: 02/04/2026** [redacted] **Darren STEWART OBE** **HM Area Coroner for Suffolk**