Date: 21 April 2026
[redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: Secretary of State for Health and Social Care

CORONER

I am James Thompson, Assistant Coroner for Gateshead & South Tyneside.

CORONER'S LEGAL POWERS

I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009, Regulations 28 and

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

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

INVESTIGATION AND INQUEST

On 26 September 2022 I commenced an investigation into the death of Theresa Lydon. The investigation concluded at the end of the Inquest on 16th April 2026.

A Narrative Conclusion with a finding of neglect was made.

1a. Intra-Abdominal Haemorrhage

1b. Complications of Subtotal Colectomy Operation for Ulcerative Colitis (8.9.22)

II. Heparin Treatment for Pulmonary Thromboemboli

CIRCUMSTANCES OF THE DEATH

Mrs Theresa Lydon was diagnosed with ulcerative colitis in May 2021 and prescribed Balsalazide to treat this condition. This drug was not issued to her until June 2022. The period the drug was taken was limited once it was prescribed. The evidence does not allow a determination on what part it's omission during this period made in her death.

She was not able to access support from the Inflammatory Bowel Disease nurses in the community after her diagnosis in May 2021 as a referral to the service was not progressed and subsequently due to her admission to hospital before she attended a scheduled appointment set for September 2022. It cannot be said on the evidence if this then contributed to her death.

Mrs Lydon suffered with ongoing continuous severe Ulcerative Colitis on the evidence from July 2022 until her death, she presented to hospital on four occasions during this period.

On the first occasion the severe Ulcerative Colitis was recognised as was an infection. Treatment was commenced for both the Ulcerative Colitis and the infection. She was discharged once improved, but it was accepted her severe Ulcerative Colitis was still present and further treatment was likely to be necessary.

She was readmitted to hospital on three occasions in August 2022. The significance of her severe Ulcerative Colitis was not fully appreciated by those treating her on these

admissions and was not definitely recognised until the fourth and final admission to hospital.

The absence of repeated blood tests during her admission to hospital between 8-15 August 2022 prevented those treating her from identifying the severity of her illness and adopting treatment which on the evidence would have prolonged her life. This contributed to her death.

By the time of her final admission to hospital, opportunities to administer alternative treatment in the form of a biological treatment as opposed to surgery were ineffective. She was severely debilitated by lengthy hospital admissions, her medical condition and treatment, which made surgery the only available treatment available to her and was seen as a very high risk procedure for those reasons.

Mrs Theresa Lydon died on 18th September 2022 at South Tyneside District General Hospital, South Shields from an Intra Abdominal Haemorrhage.
This directly arose from recognised complications from necessary and appropriate surgery to address her pre-existing Ulcerative Colitis.
The use of anti-coagulation to address the risk of a Pulmonary Thromboemboli contributed to her deterioration and death. It was an appropriate treatment to prevent her death from a Pulmonary Embolism.

The complications she suffered due to the surgery were well known and recognised by those treating her. The surgery which was undertaken was an attempt to prolong her life which despite this caused her death in concert with her Ulcerative Colitis.

Death contributed to by neglect.

CORONERS 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) During the course of the inquest it was established Mrs Lydon was diagnosed with a condition and treatment was prescribed in the form of a repeat prescription drug in May 2021. The diagnosing consultant set out the treatment plan in a letter to her GP and the format of the letter was such it was difficult for the receiving GP to see what actions were required by him.

This is compounded when paper correspondence is routinely scanned and emailed by administrators and the GP is 'drawn' to certain sections of the document by the administrators. It was remarked in evidence by the GP that all consultants seem to format their correspondence differently and there is no uniform format so a GP can see clearly at the outset what the treatment plan is and what action needs to be taken.

Evidence from the Hospital Trust in question stated they had changed the format of this type of correspondence to make it easier to identify the actions to be taken. In Mrs Lydon's case, the drug she was prescribed in May 2021 was not identified from the correspondence and was supplied to her in June 2022 when the situation was discovered. Whilst a remedy has been implemented locally I have a concern that nationally there is a risk of future deaths if important correspondence contained treatment plans is not clearly communicated to those responsible for implementing them.

(2) Evidence was given at inquest that when a diagnosis is made by a specialist in a secondary care setting, if drugs are to be prescribed that must be undertaken by the patient's GP. It was confirmed that the current practice does not allow for a specialist to issue a prescription for the required drugs at the point of diagnosis and then instruct the patient's GP to continue the process. In Mrs Lydon's case this would have ensured she received the clinically indicated drugs immediately.

(3) On Mrs Lydon's admission to hospital in Gateshead in July 2022 certain investigations, treatments and diagnosis were made. She was then discharged and returned to hospital in South Tyneside, a neighbouring NHS Trust in August for what amounted to a further 3 hospital admissions there before her death. Evidence was heard that the doctors in South Tyneside whilst aware of her recent admission in Gateshead could not access her medical records for that admission. They requested them in August, but they were not supplied until November, after she had died.

I understand much work regionally has been undertaken since 2022 with North East England based NHS Trusts to make 'real time' access to patient records possible, but whilst improved it is not complete and this is also a national issue I understand.

Given the two hospitals Mrs Lydon was a patient in are only 6 miles apart it raises a concern that doctors attending Mrs Lydon in one location are denied access to another hospital records so close at hand and I understand this is not a position unique to these hospitals. To me, the inability of doctors to promptly access a patient's medical records from other NHS Trusts to provide the best possible care creates a risk of future deaths.

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

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 16 June 2026.

Your response must contain details of action taken or proposed to be taken, setting out timetable for action.

COPIES AND PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons, the family of Mrs Lydon, South Tyneside & Sunderland NHS Foundation Trust, Gateshead Health NHS Foundation Trust, East Wing Surgery, [redacted] 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 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.

SIGNATURE

Date: 21 April 2026