

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. NHS England
1	CORONER I am Jyoti Gill, assistant coroner, for the coroner area of Essex
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 14 March 2025 an investigation into the death of Glen Edward Robert Jay commenced. The investigation concluded at the end of the inquest on 27 February 2026. The conclusion of the inquest was a narrative conclusion which stated that Glen Edward Robert Jay died of complications arising from a necessary surgical procedure.
4	CIRCUMSTANCES OF THE DEATH Glen Edward Robert Jay was admitted to Broomfield Hospital on 10 February 2025 as part of planned preoperative preparation for abdominal wall reconstruction. Mr Jay had a history of adhesional small bowel obstruction. During this admission an emergency laparotomy was performed to address a small bowel obstruction with suspected associated ischaemia and a further resection of the bowel followed by an anastomosis and an abdominal wall closure. Mr Jay was admitted to the intensive care unit on 24 February 2026. Following surgery on 26 February 2026 Mr Jay did not regain consciousness and his condition deteriorated following severe sepsis. Sadly, Mr Jay died at Broomfield Hospital (Heybridge Ward) on 8 March 2025.
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 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. – - There are other clinics nationally who may be offering patients Preoperative Progressive Pneumoperitoneum (PPP) to patients who have a history of adhesional small bowel obstruction (ASBO). Mid & South Essex NHS Foundation Trust have updated their protocol to include a prior history of recurrent ASBO, as a contraindication to PPP. This is because it can induce ASBO due to stretching of any intra-abdominal or hernia sac adhesions and consequent obstruction of involved loops of small bowel.
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 25 May 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 [REDACTED] (wife and next of kin of Mr Jay) Chief Executive of Mid & South Essex 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 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: 10 May 2026 [REDACTED] Assistant Coroner for Essex