David Place
Senior Coroner for the City of Sunderland

	REPORT TO PREVENT FUTURE DEATHS **REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013**
1.	**CORONER** I am Abigail Combes, His Majesty's Assistant Coroner for the City of Sunderland.
2.	**DATE OF REPORT** This 8th day of July 2026
3.	**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.
4.	**THIS REPORT IS BEING SENT TO:** **NHS England** You are under a duty to respond to this report within 56 days of the date of this report, namely by 3rd September 2026. I, the Coroner, may extend the period if an appropriate application is made.
5.	**YOUR RESPONSE** 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.

[redacted]

6.	**SUMMARY OF CORONER'S CONCERN** Marie Bell underwent a FIT test in January 2025. The result was a positive result, which she was made aware of in February 2025 and sent for a colonoscopy. Unfortunately due to imminent hip surgery she was unable to get into the positions required for the administration of the colonoscopy, and it would appear that she was then deemed to have declined further testing from the Screening Service. She still had symptoms, but these were not recognised as being significant until July 2025, when she was referred for a CT scan which identified a mass within the abdomen. This mass was ultimately found to be cancerous following a surgical procedure and, although the mass had not significantly increased in size, the delay between February and July for the surgery meant that Marie's abdomen was distended, and the surgery was more complicated as a result. Ultimately Marie died as a result of an error in the surgery, which was not caused by the delay, however there will be cases where the delay is of significant impact on patient outcome. The primary concern is that there seems to be an erroneous view that Marie had declined testing from the Screening Service due to a physical condition, which meant she could not have the test which was offered. There is no evidence that an alternative, such as a CT scan, was offered which would have offered an earlier diagnosis.
7.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths, and I believe you have the power to take such action.
8.	**INVESTIGATION AND INQUEST** On 7th August 2025 I commenced an Investigation into the death of Marie Bell, aged 58 years. The Investigation concluded at the end of the Inquest on 7th July 2026. The medical cause of death was confirmed as: - Ia Faecal Peritonitis Ib Latrogenic Small Bowel Perforation (operated) Ic Obstructing Sigmoid Bowel Cancer (operated) On 25 July 2025 Marie Bell underwent a procedure to remove a bowel obstruction. There were no noted complications within that surgery however it would appear that during the procedure the diathermy implement has made contact with the small bowel causing a scorch and subsequent perforation which was not noted during the surgery. This perforation was not noted until Marie deteriorated on 27 July 2025 and despite surgery to repair the perforation on 28 July 2025 it was unsurvivable and she died at hospital on 29 July 2025. I gave the following narrative conclusion: - 'On 25 July 2025 Marie Bell underwent a procedure to resolve a bowel obstruction. Unfortunately she suffered a perforation of her small bowel as a consequence of the surgery and went on to develop faecal peritonitis resulting in her death on 29 July 2025.'
9.	**CIRCUMSTANCES OF DEATH** On 25 July 2025 Marie Bell underwent a procedure to remove a bowel obstruction. There were no noted complications within that surgery, however, it would appear that during the procedure the diathermy implement had made contact with the small bowel causing a scorch and subsequent perforation which was not noted during the surgery. This perforation was not noted until Marie deteriorated on 27 July 2025 and, despite surgery to repair the perforation on 28 July 2025, it was unsurvivable and she died at hospital on 29 July 2025.

	The obstruction was directly related to a tumour, located within Marie's bowel, which had been present in February 2025 when Marie had a positive FIT test, and therefore could have been diagnosed earlier and surgery performed earlier. The reason for not diagnosing cancer in February 2025 is that Marie was physically unable to undergo a colonoscopy due to imminent hip surgery, and the Screening Service deemed her to therefore be declining investigations rather than identifying alternative methods of investigation. This did not make a difference to the outcome for Marie but may for others.
10.	**CORONER'S CONCERNS** During the course of the inquest I heard evidence 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:- Where one means of investigation is not suitable for a patient due to comorbidities or conditions this does not mean that the patient is declining all investigations and an alternative should be explored. I shall be glad to be told of any learning arising from Marie's death and timescales and results of your review.
11.	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: • Family and their Solicitors and Counsel • South Tyneside and Sunderland NHS Foundation Trust I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the Coroner, about the publication of the contents of this report in line with Chief Coroner's Prevention of Future Deaths Reports Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
	SIGNATURE  His Majesty's Assistant Coroner for the City of Sunderland