REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

1.	**CORONER** I am Dr Elizabeth Didcock, HM Assistant Coroner, for the coroner area of Nottingham City and Nottinghamshire
2.	**DATE OF REPORT** 28.7.26
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** 1. [redacted] Interim Chief Executive, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust You are under a duty to respond to this report within 56 days of the date of this report, namely by 22.9.26. 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.
6.	**SUMMARY OF CORONER'S CONCERN** 1. That patients on the wards at Bassetlaw District General Hospital will have inaccurate and inadequate completion of fluid balance charts, particularly when there is persistent vomiting 2. That nursing assessments, will not identify a deteriorating patient, thus preventing necessary escalation for medical assessment 3. That the Trust Pain guideline will not be followed, leading to a delay in diagnosis and necessary management of an acute abdominal condition 4. That there will be continuing confusion as to the arrangements for surgical review at Bassetlaw District General Hospital at weekends and out of hours
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 15.9.25, I commenced an investigation into the death of Eunice Mair Brookes. The investigation concluded at the end of the inquest on the 24.7.26. The conclusion of the inquest was a Narrative as follows: Eunice lived alone independently, with family support. She had a background history of hypertension, Type 2 Diabetes Mellitus, CKD, and reflux in association with a large Hiatus Hernia. The Hiatus Hernia was troublesome at times, causing episodes of pain and nausea due to food not passing from the stomach, relieved by drinking and then vomiting. Unfortunately, the Hiatus Hernia was not amenable to elective surgery as the procedure was thought to be high risk in light of her age, and other comorbidities.

	The Hiatus Hernia became incarcerated, and partially twisted, such that Eunice developed severe and persistent vomiting and severe and worsening abdominal pain from 3.9.25. She was admitted to Bassetlaw Hospital on that day, and the obstruction secondary to the incarcerated hernia with partial gastric volvulus, was not recognised. This untreated condition led to her clinical deterioration, with compromise to stomach blood supply and then to a perforation of her stomach, and then to her death. Had the issues with the Hiatus Hernia, and its blockage and twisting, been recognised as they should have been, Eunice would have had a nasogastric tube placed on admission, or in the days prior to her death, and on balance she would not have died when she did. Eunice's death was contributed to by neglect
9.	**CIRCUMSTANCES OF DEATH** Eunice died on 8.9.25 at Bassetlaw District General Hospital. She had been admitted on 3.9.25 with a suspected gastrointestinal obstruction. This was not recognised as it should have been, and no surgical review was obtained and no nasogastric tube placed urgently as should have occurred. She had a known Hiatus Hernia, and was presenting with a significant change in her usual symptoms. She had significant vomiting of dark brown liquid (the colour and extent likely secondary to mucosal irritation and stomach outlet blockage). She had severe upper abdominal pain with distension. The working diagnosis of constipation did not explain these symptoms and signs. Eunice continued to deteriorate throughout her admission from an undiagnosed incarcerated Hiatus Hernia, likely with volvulus. This was not recognised and led to compromised blood supply to her stomach and to a gastric perforation, and to her death. There are issues of care during her final admission that have probably caused, or made a more than minimal, negligible or trivial contribution to her death as follows: a) There was no Emergency Department or Acute Medicine Consultant review during her admission, until she was in extremis on the morning of 8.9.25, some 3-4 hours prior to her death b) There was no surgical review during her admission, or throughout, until the morning of 8.9.25. c) There was inadequate monitoring of fluid input and output, most particularly the lack of recording of the large volumes of vomit

	d) The Trust Adult Pain guideline was not followed, with inadequate pain relief provided, and a lack of escalation to the medical team for review of worsening pain. e) There was no recognition of Eunice's deterioration, on 6.9.25 and no senior review on that day f) There was uncertainty as to how to obtain an urgent surgical review on 7.9.25 (a Sunday), such that it did not occur g) The family, who continued to articulately raise their concerns as to Eunice's deterioration, were not listened to or believed h) No Consultant opinion, or Critical Care Outreach team opinion, was offered on 7.9.25 when this was requested by the family i) No nasogastric tube to achieve stomach drainage was placed on admission, or throughout, until attempts were made to pass a tube when she was dying on the morning of 8.9.25
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 as set out in Box 6 above.
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: *[please do not use individual's names, but instead roles/titles]* • **Family** • **Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust** • **Care Quality Commission** • **Nottingham and Nottinghamshire Integrated Care Board** 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 PFD 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.
12.	**SIGNATURE**  **Dr Elizabeth Didcock** **HM Assistant Coroner** **Nottinghamshire**