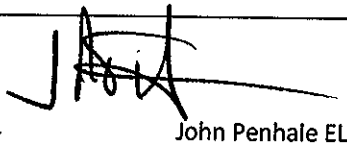
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Mr Peter Herring Chief Executive Shrewsbury and Telford Hospital NHS Trust Mytton Oak Rd Shrewsbury Shropshire SY3 8XQ
1	**CORONER** I am John Penhale Ellery Senior Coroner, for the coroner area of Shropshire, Telford & Wrekin.
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 28th April 2014 I commenced an investigation into the death of Martin Rowland HILL deceased, 58 years old. The investigation concluded at the end of the inquest on 4th August 2014. The conclusion of the inquest was Natural cause, preventable by appropriate response following abdominal x-ray. The medical cause of death was: Ia) Aspiration Pneumonia due to Ib) Intestinal Obstruction due to Ic) Sigmoid Colon Volvulus
4	**CIRCUMSTANCES OF THE DEATH** The deceased died at the Villa Nursing Home, Madeley, Telford on the 24th April 2014 having been admitted to A&E at the Princess Royal Hospital on the 20th April and discharged later that day. An abdominal x-ray was taken. On examination by the doctors no abnormality was found. The subsequent consultant radiologist report on the 22nd April revealed a degree of small bowel obstruction. That report, or its contents, was not seen by any subsequent doctor, with the deceased being treated for constipation.
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 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) The abdominal x-ray report was not seen by any doctor and all subsequent diagnoses were made without knowledge of its content. (2) Although the doctor in A&E did not have had access to it at that time he stated that had he known of its content he would have referred the patient for surgical review and he would not have been discharged when he was. (3) The 2 GPs who saw the deceased on the 22nd and 24th respectively stated that on the information they had Mr Hill had been discharged with a diagnosis of constipation. Had they been aware of the content of the x-ray report it would have raised the concerns which they had to the level where they would have then arranged for Mr Hill's readmission to hospital.

	(4) On the 20th April there was radiological evidence of small bowel obstruction, according to the independent pathologist, most likely episodic. Over the next 4 days it became progressively worse, described by the pathologist at PM as hugely distended. The prospects of successful intervention declined over the subsequent 4/5 days. The report, when available, was not acted upon. (5) An additional concern arose separate to this. Mr Hill, when he was discharged on the 20th April, had been prescribed medication. Mr Hill should have left the hospital with that medication but none was provided to him. It is unlikely that its absence had any material effect in this case but it could in others. (6) For completeness, and it is an issue which arose in an earlier Inquest, no discharge summary was sent to the patient's GP. This appears to have been an exception to normal practice and an indication was given at the Inquest that this issue has already been addressed. Confirmation of this is sought.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 1st October 2014. 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: 1. [redacted] Sister of deceased 2. MDDUS (for the two GP's) 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.
9	 6th August 2014 John Penhale ELLERY