	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Tees, Esk and Wear Valley**
1	**CORONER** I am Andrew Tweddle Senior Coroner, for the coroner area of County Durham and Darlington.
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. (see attached sheet)
3	**INVESTIGATION and INQUEST** On 9th March 2016 I commenced an investigation into the death of Pamela Gressman, 65 years. The investigation concluded at the end of the inquest on 1st August 2016. The conclusion of the inquest was a narrative- The result of ingesting a number of foreign bodies, one or more of which led to a perforation of the colon. The medical cause of death was; 1a) Hospital Acquired Pneumonia, 1b) Colonic Perforation, 1c) Ingested Foreign Body, 2) Depression, Laparotomy with Sigmoid Colectomy & Formation of Stoma, Bleeding Duodenal Ulcer, Malnutrition, Diet Controlled Diabetes, Previous Stroke, Ischaemic Heart Disease, Chronic Obstructive Pulmonary Disease.
4	**CIRCUMSTANCES OF THE DEATH** The deceased at some time ingested a series of foreign bodies which were found internally during an operation. She had been admitted as a voluntary patient to West Park Hospital, Darlington. It is unknown when the items which were found within her during the operation were ingested. It is not known whether she had actually ingested all or any of the items which she said she had ingested which led to her being admitted to hospital in January 2016. She reported abdominal pains which were not associated to be linked with the swallowing of foreign bodies. The Consultant Psychiatrist did not believe that she had swallowed foreign bodies during the period of admission to the hospital and that she probably swallowed various items prior to admission. During her period of admission there is no documented enquiry having been made as to how physically well she was in relation to the items which she had allegedly swallowed nor was any consideration given to discussing with her whether such items had been passed naturally from her body nor was any system in place to be able to monitor if and when any foreign bodies were excreted from her body. It is possible that such foreign bodies within her system could remain benign for a period but likewise could move and cause serious harm or become life threatening. There is nothing to suggest that this important matter was given any significant consideration by those responsible for her care.
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. – Whilst it is clear that considerable attention was given to the deceased's mental health, insufficient consideration or no consideration was given to any physical effects which might ensue from her ingesting the foreign bodies that she reported she had and which

	led to her period of hospitalisation. Thus little or no thought was given to any link between such items and her presentation with abdominal pain in January 2016. The absence of a clear treatment and observation plan in such circumstances could lead to a risk of similar fatalities in the future.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 Tuesday 27th September 2016. 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] and the Care Quality Commission. 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	**[DATE]** **[SIGNED BY CORONER]**