REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Chief Executive, The Northern Care Alliance NHS Trust
1	**CORONER** I am Mr. Matthew Cox, Assistant Coroner for the Coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On 27 January 2021 I concluded the Inquest into the death of Mrs. Monica McCormick who died on 24 May 2020 at her home address. I reached the following conclusion in respect of Mrs. McCormick's death : Natural Causes to which neglect contributed
4	**CIRCUMSTANCES OF DEATH** The deceased who was then aged 79 years but had no known significant previous medical history developed stomach pain at the beginning of October 2019 leading to a CT scan at Fairfield General Hospital on 6 October 2019 which revealed a colonic perforation with a differential diagnoses between focal diverticulitis and perforated proximal neoplasm. She was transferred to North Manchester General Hospital where she underwent an emergency laparotomy, sigmoid colectomy and end colostomy on 8 October 2019. The report on the pathology specimen taken at the time of the operation was dated 15 October 2019. This showed moderately differentiated adenocarcinoma with extramural, vascular lymphatic and peri-neural invasion. The pathology report was not communicated to the deceased although she remained an inpatient at North Manchester General Hospital until 16 October 2019. The diagnosis was not reported to her general practitioner at the time she was discharged. Scheduled outpatient appointments on 11 December 2019, 6 January 2020, 17 February 2020 and 9 March 2020 were all cancelled by the hospital. On 6 April 2020, a Colorectal Consultant at North Manchester General Hospital noted the results of the pathology specimen removed in October 2019 and it was only then that the deceased and her general practitioner were informed of the diagnosis. A subsequent CT scan identified that the cancer had spread into the liver and abdominal cavity. The deceased's condition deteriorated and she died at her home address on 24 May 2020. Had appropriate consideration been given to the pathology report in October 2019 the deceased would have been referred for adjuvant chemotherapy at a time when she was still feeling well and such treatment would on the balance of probabilities have prolonged her life.
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:- Evidence was heard that the pathology sample was not followed up because despite labelling the specimen to include the word malignancy the operating clinicians did not complete an online "suspected cancer upgrade form" at the time of surgery. However there were also many opportunities to identify and rectify the initial error which were also missed: 1. Appropriate consideration was not given to the deceased's medical records at the time of her discharge from hospital. 2. The pathology report was not communicated to her general practitioner at the time she was discharged from hospital. 3. Appropriate consideration was not given to her records at the time that each outpatient appointment was cancelled As a consequence of the initial error and the missed opportunities the deceased was not referred for adjuvant chemotherapy until shortly before her death. Evidence was heard that an earlier referral would have prolonged her life.
6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 31 March 2021 . 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 namely:- The legal representatives for Mrs. McCormick's family. 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 from. 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.
-	Date: 3 February 2021 Signed: