Kally Cheema LLB | Senior Coroner| Cumbria

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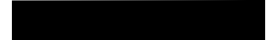

13 January 2022

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: (1) North Cumbria Integrated Care NHS Foundation Trust (2) ████████ (Chief Executive Officer, EMIS Group)

1	**CORONER** I am Mr Robert Cohen, HM Assistant Coroner for Cumbria
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 23 August 2021 an investigation was commenced into the death of Darran Busby. The investigation concluded at the end of the inquest on 13th January 2022. The conclusion of the inquest was Suicide 1b 1c II
4	**CIRCUMSTANCES OF THE DEATH** On 14th August 2021 Mr Darren Busby was at home with his family. He ████████ ████████ and ended his life. Prior to his death Mr Busby had complained of headaches and had been referred for an MRI scan of his head. He had had the MRI scan in

April 2021. It emerged in the course of my investigation that the outcome of that MRI scan was never reviewed by a clinician. I did not conclude that this was causative of, or related to, Mr Busby's death. However, the circumstances in which it was not reviewed give me cause for concern that there is a risk of future deaths unless action is taken.

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. -

After it became apparent that the result of Mr Busby's MRI scan had not been reviewed by a clinician, a consultant employed by North Cumbria Integrated Care NHS Foundation Trust ('the Trust') undertook an investigation. He noted that the Trust use EMIS as an electronic patient record. He explained that the Trust used a separate system called ICE to gather the results of tests or scans. ICE is capable of linking to EMIS to input results into the EMIS system. Once a test result has been linked to a patient in EMIS the result enters the EMIS record as a provisional result pending review, and is placed on a work list. The consultant or a deputy then reviews the result, files it with or without comment and records any actions taken. EMIS provides two options: 'file no comment' and 'file and comment'. Results of blood tests which are undertaken to monitor treatment and which are normal may be filed without comment. If there is an abnormality flagged, however, EMIS will default to the file with comment dialogue box even if file no comment is selected. This acts as a safeguard against missing a significant finding. Unfortunately, there is no flag attached in the ICE system for abnormal radiology results, and so no failsafe exists for defaulting to a 'file and comment' if a significant positive or negative finding is reported.

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In the course of investigating what occurred in relation to Mr Busby's MRI scan, it was determined that clicking more than once on the 'file no comment' button will result in the displayed result being filed, but will also result in filing of the next in the list if that result has no flag indicating the result is abnormal. Thus if a radiology result lies below a normal blood result and a clinician inadvertently double clicks to file the first result, the radiology result is also filed without comment and without the result being displayed. Furthermore, multiple clicks up to 6 (and perhaps even beyond) will lead to multiple filings. In the result it is possible that a clinician inadvertently clicking 'file no comment' more than once on one result would cause results which require urgent follow up being filed without a clinician being involved.

I am concerned that this might lead to lost opportunities to treat patients whose scans reveal, for instance, early malignancies. It might also mean that scans which reveal the need for urgent action will be overlooked. I am therefore concerned that future deaths will occur.

I was impressed by the candour of the report provided to me and the efforts that the Trust have already taken to resolve this issue. However I noted that the evidence I received was that "In order to fix this issue it is likely it will require action by the publishers of EMIS to prevent accidental filing of results. To attempt to mitigate this issue whilst a permanent fix is sought I have worked with colleagues from Pathology and Radiology to attempt to have all radiology results (where the greatest risk lies) flagged within the ICE system as abnormal, so that any attempt to file the result prompts via the file and comment dialogue box. Unfortunately at the time of writing this letter the flag, which is triggered in ICE for any radiology report originating within Cumbria Neuroscience, does not carry through to EMIS

and we continue to seek a local solution to mitigate this newly identified risk."

In the circumstances I have concluded that it is necessary for action to be taken to prevent future deaths.

ACTION SHOULD BE TAKEN

6 In my opinion action should be taken to prevent future deaths and I believe you (1) North Cumbria Integrated Care NHS Foundation Trust and (2) EMIS Group have the power to take such action.

YOUR RESPONSE

7 You are under a duty to respond to this report within 56 days of the date of this report, namely by **11th March 2022** 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.

COPIES and PUBLICATION

8 I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: [redacted]

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 13 January 2022

Signature

Robert Cohen, HM Assistant Coroner for Cumbria