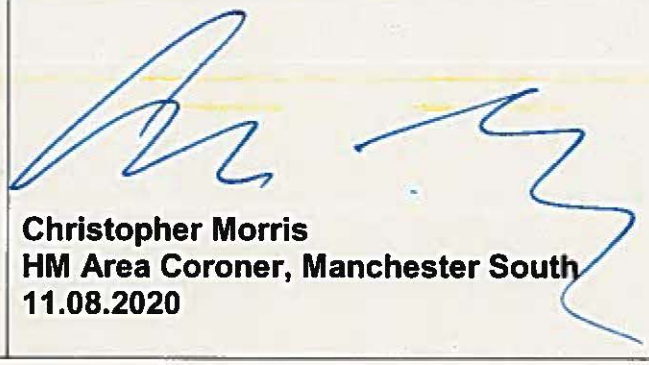
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Dr [redacted], President, Royal College of Radiologists
1	CORONER I am Chris Morris, Area Coroner for Greater Manchester South.
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 20th February 2020, Alison Mutch OBE, Senior Coroner for Greater Manchester South, opened an inquest into the death of Sylvia Scully who died at Tameside General Hospital, Ashton under Lyne on 10th February 2020, aged 86 years. The investigation concluded at the end of the inquest, which I heard on 20th and 28th July 2020. The court heard evidence that Mrs Scully died as a consequence of:- **1a) Intra-Abdominal Sepsis;** **1b) Hollow Viscus Perforation;** **II) Frailty, Ischaemic Heart Disease.** The inquest concluded with a **Narrative** conclusion to the effect that **Mrs Scully died as a consequence of a hollow viscus perforation which was first formally diagnosed over 10 hours after she attended hospital complaining of abdominal pain and vomiting. By the time this diagnosis was made, Mrs Scully's condition had deteriorated to such an extent that she was too unwell to withstand emergency surgery. Mrs Scully's death was contributed to by neglect.**
4	CIRCUMSTANCES OF THE DEATH On 9th February 2020, Mrs Scully became unwell with sudden onset abdominal pain and vomiting. She was taken to Tameside General Hospital Emergency Department, arriving at about 12:30. Following triage and at about 14:30, Mrs Scully was first seen by a junior doctor who arranged tests and examined her, recording findings of tenderness and

	guarding. Despite this, Mrs Scully's medical history and an abnormal venous blood gas result, she was not referred to the surgeons until around 16:18 by which stage other investigation results were available. When reviewed by the surgeons, a management plan was arrived at which included an urgent CT scan intended to provide a definitive diagnosis as to the cause of her acute abdomen. The consultant radiologist reported another patient's scan in error. This error was ultimately appreciated and a correct report issued, revealing a hollow viscus perforation. By this time however, Mrs Scully's condition had deteriorated to such an extent that she was too unwell to withstand emergency surgery. Mrs Scully died in hospital on 10th February 2020 as a consequence of complications of a hollow viscus perforation.
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 court heard evidence that the Consultant Radiologist on-call for the Trust and reporting on urgent out-of-hours imaging from home, had more limited remote access to relevant systems than radiologists working for remote reporting companies and had been provided with less equipment than such an individual. Given the importance of effective out-of-hours reporting of imaging to emergency care, it is considered authoritative guidelines as to requisite access and recommended equipment could assist in reducing such variations.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you and 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 6th October 2020. 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 Mrs [redacted] of Bond Turner as the family's legal representative, in addition to Ms [redacted] of Weightmans LLP who appeared at the inquest on behalf of Tameside and Glossop Integrated Care NHS Foundation Trust. 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	 **Christopher Morris** **HM Area Coroner, Manchester South** **11.08.2020**

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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Ms [redacted], Chief Executive, Tameside and Glossop Integrated Care NHS Foundation Trust
1	CORONER I am Chris Morris, Area Coroner for Greater Manchester South.
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
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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. Notwithstanding the circumstances of Mrs Scully's death, the Trust's routine clinical governance processes have not resulted in a formal Serious Untoward Incident investigation or similar taking place in respect of the care and treatment provided to her. This is a matter of concern given the great importance to patient safety of robust and effective investigations being undertaken in a timely fashion; 2. A Rapid Assessment and Treatment Model was not in use at the Trust's Emergency Department at the time of Mrs Scully's attendance in respect of 'walk-in' patients. Such a paradigm would have seen Mrs Scully assessed early on by a senior doctor who had the experience and authority to promptly initiate all relevant investigations (including ordering CT Scans) and commence treatment, in advance of review by the surgical team.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you and 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 6th October 2020. 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 Mrs [redacted] as the family's legal representative, in addition to Ms [redacted] who appeared at the inquest on behalf of the Trust. I have also sent a copy of my report to the Care Quality Commission, Healthcare Safety Investigation Branch and Tameside CCG, who may find it useful or of interest. 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	**Christopher Morris** **HM Area Coroner, Manchester South** **11.08.2020**