REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Tameside CCG, Secretary of State for Health and Social Care
1	CORONER I am Alison Mutch, Senior Coroner, for the Coroner Area of 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
3	INVESTIGATION and INQUEST On25th March 2021 I commenced an investigation into the death of Serena Naomi Roberts. The investigation concluded on the 10th September 2021 and the conclusion was one of Narrative: Died from a complication of ovarian cancer not diagnosed until after her death. When referral to secondary care was delayed, and her risk factors not fully recognised when triaged by secondary care. The medical cause of death was 1a Septic Shock 1b Intra-abdominal sepsis. 1c Ovarian Cancer II Morbid obesity
4	CIRCUMSTANCES OF THE DEATH Serena Naomi Roberts was referred in April 2020 for an ultrasound scan having reported symptoms of recurrent very heavy vaginal bleeding. Her BMI was high. The ultrasound was only able to report a partial view. It indicated endometrial thickness and lack of success in scanning her ovaries. It was recommended she be referred to a gynaecologist for review. The GP who saw her to discuss her scan did not refer her to a gynaecologist. In November 2020 at a consultation the GP realised a referral had not been made and made one. The letter was marked urgent. The e-referral completed by the surgery marked it as routine. The referral was limited in detail and did not reference her BMI which NICE guidance on managing heavy menstrual bleeding makes clear is a risk factor. The referral letter lacked details of the heavy bleeding and treatment. The triage by the gynaecology team at Tameside General Hospital put the referral as routine. It is unclear the basis on which the decision was made given the delayed referral and the presentation and the findings of the May ultrasound. In a series of telephone appointments following

	November 2020, the treating medical staff at the GP practice did not recognise that she had not yet seen a gynaecologist despite the request to see her urgently and it was not chased up. On March 4th, 2021 she attended A+E at Tameside General Hospital due to her pain and heavy vaginal bleeding. She was discharged with painkillers. There was to be a call from emergency gynaecology for an ultrasound scan. This did not happen. On 9th March there was a telephone consultation with a consultant gynaecologist who referred her for a transvaginal ultrasound. The appointment was not face to face due to Covid. As a consequence, Serena Roberts was not examined, and her BMI was not recognised. On 20th March 2021 Serena Roberts attended Tameside General Hospital as an emergency patient. She was operated on and found to have a mass that was tube/ovarian and extensive peritonitis. Histology later confirmed that the mass was an ovarian cancer with a significant tumour necrosis. Earlier referral as an urgent case to specialist and to secondary care would on the balance of probabilities have given the opportunity to identify the ovarian cancer at an early stage put in place an earlier treatment plan to manage her cancer.
5	<u>CORONER'S CONCERNS</u> 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 inquest heard that there were significant delays in patients being seen in secondary care for gynaecological referrals from GPs. The inquest was told that these delays had now increased. In November 2020 the wait time for an appointment was 1 month for an urgent appointment and 4 months for a routine appointment. The wait times now in Tameside for gynaecology were 8 months for a routine appointment and 4 months for urgent appointments. The increase in wait times reflected a national picture the inquest was told and reflected a significant backlog and a rising demand across the NHS. 2. The inquest heard that understanding and application of the NICE guidance on heavy premenstrual bleeding in General Practice was a factor in recognising the risk to her health and that the risks around heavy premenstrual bleeding were not well understood in General Practice and in particular where it was necessary to expedite referral to specialist services. 3. The quality of the documentation in the referral to secondary care form the GP was poor and the inquest was told that this hampered the triage of her case by secondary care. Standardisation of GPs referrals in relation to detail and guidance regarding key information for referral would assist with effective triage and identification of high risk patients by secondary

	care. 4. There was no evidence available that GP practices had clear systems of follow up in relation to referrals to identify where they had not taken place or identify if the risk had increased and to escalate the referral.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you 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 17/12/2021. 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 yourselves (Tameside CCG), [redacted], Secretary of State for Health and Social Care 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	**22/10/2021**  **Alison Mutch** **HM Senior Coroner** **Manchester South**