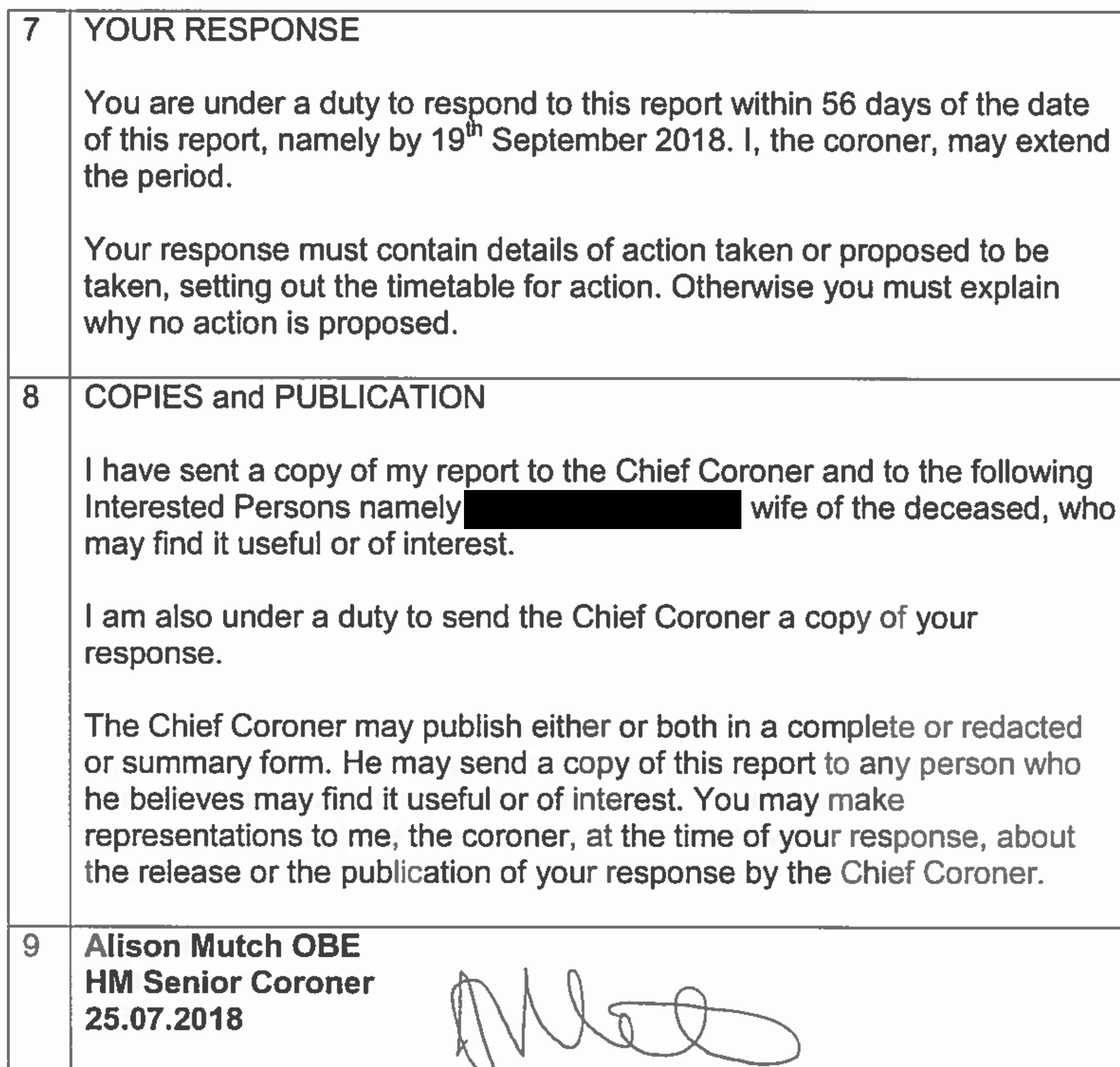
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Chief Executive of Stockport NHS Foundation Trust, Greater Manchester Strategic Health Group, Royal College of Pathologists, Secretary of State for Health.
1	CORONER I am Alison Mutch, Senior Coroner, for the Coroner area of South Manchester
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 On 7th April 2017, I commenced an investigation into the death of Robert Thomas Wrinch. The investigation concluded on the 21st June 2018 and the conclusion was one of **Narrative**: Died from the recognised complications of an undiagnosed metastatic spinal malignancy. The medical cause of death was; 1a) Bronchopneumonia;1b) Metastatic spinal malignancy (undifferentiated carcinoma); and II) Ischaemic heart disease
4	Robert Thomas Wrinch lost a significant amount of weight in 2016 and was in significant pain in his back. On 19th January 2017, it was identified that there was strong suspicion of malignancy in T10 and T11 of the vertebrae. A biopsy took place on 6th February 2017. Robert Thomas Wrinch continued to deteriorate, his pain increased and his mobility decreased. He was readmitted to Stepping Hill Hospital where he continued to deteriorate. He developed pneumonia as a consequence of his immobility. His biopsy results from 6th February 2017 were awaited at the time of his death. Post mortem examination showed that he had stage 4 undifferentiated spinal cell malignancies at T10 and T11 of his vertebrae. This was the cause of the chronic back pain and consequential loss of mobility.

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 Inquest heard evidence that the pathology department at the Trust had no system for tracking samples. As a result, it was unclear when samples had been received and analysis had taken place. There was no documentation of conversations with other clinicians and so, it was difficult to be clear about the chronology of events. Transmission dates of the sample to another Trust were unclear. It was also difficult to know on what date the report of the pathologists findings had been issued to the treating clinician. It was unclear if these issues are specific to the pathology department of the Trust or more widespread. 2. The Trust had a system of issuing reports digitally to clinicians to speed up receipt. In addition the Inquest were told that due to preferences of clinicians paper copies were also produced and sent via internal mail to the treating clinicians. The Inquest heard that the responsible orthopaedic consultant relied on wholly on the paper system although this built in delay. 3. At the Trust, some departments such as the respiratory department had clear tracking systems to identify outstanding pathology reports. Other departments such as orthopaedics did not. As a result, clinicians could not readily identify where there was delay in receipt of information required to assess and diagnose a patient. 4. The I.T systems of the pathology department of the Trust and other hospital Trusts were incompatible with each other. This meant that transfer of information between trusts to obtain a second opinion were more difficult. 5. The Inquest heard that the delay in analysis of the sample taken was due to a backlog. The backlog was not unique to the Trust and such backlogs were prevalent across pathology departments nationally due to a local and national shortage of pathologists.
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 19th September 2018. 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 [redacted] wife of the deceased, 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	**Alison Mutch OBE** **HM Senior Coroner** **25.07.2018**