REGULATION 28: REPORT TO PREVENT FUTURE DEATHS.

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • Sir Michael Deegan, Chief Executive of MFT Copied for interest to: • Chief Coroner • Next of kin
1	**CORONER** I am **Ms Jean Harkin, Assistant Coroner, Manchester City Area**
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	**INQUEST** I concluded the inquest into the death of **Peter CARROLL** on **5th October 2018** and recorded that he/she died from: 1a **Peritonitis** **b Perforated caecal volvulus; operated on** **c Perianal squamous cell carcinoma requiring colostomy** **II Coronary artery atheroma and pulmonary embolism and obesity**
4	**CIRCUMSTANCES OF THE DEATH** The deceased had a complex medical history. He had a chronic ulcer on the need to craft for over 30 years and this developed into malignancy diagnosed in early 2017. A biopsy was taken on 6th October 2016. This was not recorded on the deceased discharge notification form and it was not until the 20th April 2017, at the result of squamous cell carcinoma, was it seen by the treating consultant. Although the delayed biopsy reporting did not contribute to this death, if such delay continues, It could result in future fatalities. An Incident Investigation Report Level 2 Comprehensive was compiled and the investigation reviewed the following:

	1. The biopsy taken on 6th October 2016 was not recorded on the deceased's discharge notes. Therefore, the treating consultant and administrative staff were unaware of the need to chase results or indeed the seriousness of the results. 2. The sample was wrongly labelled and as a result not reported to the multidisciplinary team warranting earlier action. Although certain measures have been implemented to try to prevent recurrence, I am not satisfied that this is sufficient.
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: I am concerned that there is no leading physician signing off these reports in addition to processing by input on it systems thus reducing the effectiveness of the reporting. I am concerned that a 6 month delay in reporting, on the evidence, meant that a curable treatment was not an option however if reported in a timely manner, would most likely have resulted in a favourable outcome.
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 **Tuesday 7th May 2019**. 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 Interested Persons. I have also sent it to organisations 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	**DATE:** **NAME OF CORONER:** **11th March 2019** **Ms Jean Harkin** HM Assistant Coroner for Manchester City Area **Signed:**