REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Secretary of State for Health, Greater Manchester Health and Social Care Partnership, Chief Executive of NHS England
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 On 4th June 2019 I commenced an investigation into the death of Joyce Marchant. The investigation concluded on the 9th December 2019 and the conclusion was one of **Narrative: Died from the complications of a liver abscess where the presence of the abscess was not recognised until an ultra sound on 28th May 2019 and a biopsy to drain it could not be accommodated until 31st May 2019.** The medical cause of death was **1a) Multi organ failure; 1b) Biliary sepsis with liver abscess ;1c) Choledocholithiasis**
4	CIRCUMSTANCES OF THE DEATH Joyce Marchant had a history of stones in the liver. A series of complex ERCP's in 2018 removed the stones. A MRCP on 24th January 2019 showed no residual stones. She was seen on 21st May 2019 in the outpatient clinic - liver function tests were normal. She had a raised CRP. That was reported via letter to her General Practitioner (GP). The letter was not received and she was not aware of it. Over the next few days she felt unwell. On 25th May 2019 she went to the Emergency Department at Tameside General Hospital. Her CRP was very high. She was treated for an infection with antibiotics and fluid. An x-ray showed no consolidation. No further tests were carried out until an ultra sound performed on 28th May 2019 at 11:32 am suggested biliary sepsis and queried an abscess. An abscess would not of itself respond to antibiotics and required drainage to reverse the effects. It is probable that she was well enough to undergo a drainage procedure at that time. A review that evening resulted in a CT scan on 29th May 2019. On 29th May she was deemed too unwell to transfer to Manchester Royal Infirmary. The radiologist at Tameside General

	Hospital could not accommodate a drainage procedure until 31st May 2019. There was no further discussion of the options at that stage. She continued to deteriorate and was placed on end of life care on 30th May 2019. She died at Tameside General Hospital on 1st June 2019.
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. During the course of the Inquest the evidence given was that the delay in offering the drainage procedure was attributable to a shortage of interventional radiologists which meant that the Trust could not accommodate the need for a drainage procedure until 31st May. There was greater availability at tertiary centres but transfers to a tertiary centre could take time and not be practicable. The inquest heard that if she had been at the tertiary centre when the abscess was identified she would probably have had the drainage procedure almost straight away; 2. The inquest heard that the Manchester Royal Infirmary use the postal system to provide GPs with information about blood results/follow up information. Faxes are no longer used due to GDPR. The trust propose to move to an email system for notifying GPs recognising that the use of the postal system carries delay and risk of information not reaching the GP(7% was the figure given to the inquest). Their IT system at this time is not capable of this information transfer and the information was that it would be about another 2-3 years before that was achieved. In the interim they would continue to use the postal system; 3. The MRI was the treating centre for Mrs Marchant's underlying medical problems which led to her deterioration. However there was no evidence of a clear communication strategy or treatment plan involving the DGH and Tertiary Centre. This was attributed in part to the sheer volume of demand on tertiary centres and the extent of support they can provide to DGHs.
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 10th February 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 the following Interested Persons namely 1 [redacted] on behalf of the family 2) Tameside and Glossop Integrated Care NHS Foundation Trust via Weightmans solicitors 3) Manchester University NHS Foundation Trust via Hempsons solicitors, 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** **16.12.2019**