

Our Ref:

INQ/120/19

Your Ref: 8036

Date:

01 April 2020

Mr John Ellery, Senior Coroner, The Shirehall. **Abbey Foregate** Shrewsbury **SY2 6ND** 

**Executive Suite** Trust Headquarters Royal Stoke Springfield Newcastle Road Stoke on Trent ST4 6QG

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Dear Mr Ellery

## The late Peter Edward SMITH deceased

I write further to you email dated 5 February 2020 enclosing a regulation 28 report to prevent future deaths. I am pleased to provide a response to your report addressing your concerns surrounding the death of Peter Smith.

## **Recorded Circumstances of the Death**

"On 29th September 2018 a chest x-ray indicated a potential left upper zone abnormality resulting in a CT scan being performed on 22nd November 2018 and a PET scan on 27th December 2018. Subsequent tests and investigations lead to a date for surgery on 26th February 2019. Time was of the essence but by then surgery was no longer possible. The deceased relapsed on 20th February and died on the 4th March 2019."

## 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. There was a significant delay in the diagnosis and treatment of Mr Smith's adenocarcinoma which contributed to his death on the 4<sup>th</sup> March 2019.
- 2. Time was of the essence, but tests, reports, appointments and discussions took place consecutively to the extent that by the time a final date for surgery was fixed it was no longer possible.
- 3. Had tests been conducted expeditiously and concurrently with predictable tests organised in advance it is likely that the surgery would have been able to take place significantly earlier than it did.
- 4. Although separate Trusts they were effectively treating Mr Smith's adenocarcinoma as one."

You reported this matter under paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

## **Action Taken**

The University Hospitals of North Midlands NHS Trust [UHNM] has taken the issues highlighted during the inquest seriously and I am grateful to you for raising potential areas for improvement.

The thoracic surgery department at UHNM provides a surgical service to the Shrewsbury and Telford Hospital NHS Trust [SaTH] for patients with intra-thoracic problems needing surgery, including lung cancer.

With regard to the delay in the diagnosis and treatment of Mr Smith's adenocarcinoma SaTH has produced, in conjunction with and agreed by the UHNM visiting cardiothoracic surgeons, the attached Standard Operating Procedure [SOP] – "Referral for surgical resection of proven or suspected lung cancer". SaTH has implemented the SOP and will be responding to you separately.

I sincerely hope that this report provides you with assurance that UHNM [and SaTH] have taken the matters arising from the inquest of the late Peter Smith seriously. The Trust strives to provide a high standard of care to all patients and I am grateful to you for raising these matters on this occasion and for the opportunity for us to review our processes.

I should like to extend my condolences to the family of Mr Smith and my sincere apologies that Mr Smith didn't receive the standard of care at the end of his life that he deserved.

Should you wish to discuss any aspect of this report further, please do not hesitate to contact me directly.

Yours sincerely

TRACY BULLOCK
CHIEF EXECUTIVE

