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 & 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 On 16th November 2020 I commenced an investigation into the death of Mark Jones. The investigation concluded on the 22nd December 2021 and the conclusion was one of Narrative: Died from the complications of necessary surgery. The medical cause of death was 1a Haemorrhage from tongue following surgery for squamous cell carcinoma
4	CIRCUMSTANCES OF THE DEATH Mark Deardon Jones was diagnosed with squamous cell carcinoma of the tongue. He underwent complex surgery to treat his cancer including a left hemiglossectomy of the tongue. He was discharged home on 12th November 2020. On 13th November 2020 he had a catastrophic haemorrhage at the site of the hemiglossectomy and died at his home address [redacted]
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 inquest the Court was told that there is a backlog in standard referrals such as Mr Jones being seen. This means that a referral which pre Covid meant a waiting time of approximately 2.5 months for an outpatient appointment now involves a waiting time of approximately 8 months. 2. Mr Jones' referral was sent in by his dentist to secondary care on the standard referral pathway. On receipt by the secondary care triage team the referral was assessed and based on the information provided remained on the standard referral pathway. The evidence was that a more detailed and better quality referral that included a photograph of the lesion would have probably resulted in his case being moved off the standard pathway. The inquest was told that there is no national standard or protocol in place between dentists and secondary care to provide for the routine provision of photographs to assist in triage. Such a protocol to ensure the provision of photographs by referring dentists in conjunction with more consistent provision of information would, the inquest was told, be helpful in improving the quality of triage and reduce the risk of patients needing urgent care being missed.
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 31st March 2022. 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 the family, and Manchester Foundation Trust 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 3rd February 2022**  **Ms Alison Mutch** **HM Senior Coroner Manchester South**