REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: **The Greater Manchester Health and Social Care Partnership**
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 11th May 2022 I commenced an investigation into the death of Graham Flindle. The investigation concluded on the 17th October 2022 and the conclusion was one of **Narrative: Died from complications of necessary surgery.** The medical cause of death was **1a) Pneumonia; 1b) Right hemicolectomy; 1c) Cecal cancer; and 2) Chronic obstructive pulmonary disease**
4	CIRCUMSTANCES OF THE DEATH Graham Flindle had rectal bleeding and a low haemoglobin in November 2021. A sigmoidoscopy suggested the cause was haemorrhoids and they were treated. He was discharged from Tameside General Hospital. Following an outpatients review he was discharged from secondary care. His haemoglobin level did not improve significantly. On 5th April his haemoglobin was 77g/L and he was admitted to Tameside General Hospital .On 6th April 2022 a malignant tumour was identified by CT scan. An operation was required. On 20th April 2022 he was operated on. Post operatively he subsequently developed complications with his breathing. He deteriorated and died at Tameside General Hospital on 6thMay 2022.

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 that FIT tests were very effective at identifying bowel cancers at an early stage. GPs and other community health care providers, the inquest heard, have a key role in promoting the use of them where there is rectal bleeding/unexplained weight loss and other symptoms that may be consistent with bowel cancer. Use of FIT tests allows far more effective identification of patients who need to be fast tracked onto the cancer pathway. An understanding of just how effective FIT tests are was not always widely understood and promotion of them amongst all community health professionals was, the inquest was told, crucial in reducing deaths from bowel cancer; 2. The inquest was told that interpretation of haemoglobin test results and prompt referral back into secondary care if they were abnormal and remained low despite treatment was important to effective and potentially lifesaving treatment. The volume of blood results that GPs were regularly having to consider was significant and made it difficult to always identify cases that were concerning. Prompts in relation to haemoglobin test may be effective in assisting GPs juggling a large volume of results.
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 **30th December 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 Mr Flindle's Family and Tameside General Hospital, 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**  **04.11.2022**