ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. TPP Group Limited** **2. Egton Medical Information Systems Limited** **3. The Chief Executive for NHS Digital** **4. The Secretary of State for Health**
1	**CORONER** I am Carly Elizabeth Henley, Assistant Coroner, for the coroner areas of Newcastle Upon Tyne and North Tyneside.
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 20th December 2022 an inquest was opened into the death of Rachelle Naomi Ross. On 17th February 2023 I resumed the inquest. I concluded that Rachelle Ross died on 20.4.22 at her home address at 30 Haig Avenue, Whitley Bay, Tyne & Wear. She was diagnosed with Squamous Cell Carcinoma in November 2020. Despite treatment her cancer metastasised and she died on 20th April 2022. I recorded a conclusion of Natural Causes.
4	**CIRCUMSTANCES OF THE DEATH** Rachelle Ross was a 34 year old female who had been invited to attend smear tests as part of the National Screening Programme since she was 25 years old. She did not have a smear test prior to diagnosis.
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. During the course of the inquest I heard evidence from [redacted], GP Partner at the Collingwood Health Group who informed me that GP practice

	records do not include an alert from EMIS or System 1 IT systems to provide an automatic flag on a patient's GP medical records if they are classed as a non-responder for a smear test by the National Screening Service. 2. The alert system is only triggered after a patient attends a smear test. For a non-responder, they go back into the three or five year waiting list for a National Screening invitation for a smear test. 3. An automatic flag or alert when a patient fails to attend for a smear test as part of the National Screening Service, would mean that a GP surgery would not have to manually add a warning as an entry onto an individual's GP records. It would standardise the approach across all GP surgeries and could increase patient safety.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 14th April 2023. 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: Rachelle Ross's Family Collingwood Health Group 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	**17.2.23** **C E HENLEY**