REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Greater Manchester Integrated Care and 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 30th June 2022 I commenced an investigation into the death of Sandra Adina Lomax. The investigation concluded on the 4th January 2023 and the conclusion was one of **Narrative: Died from The complications of an oesophageal stent, required for the recognised consequences of chemo/radiotherapy, where the stent was not removed within the recognised timescales.** The medical cause of death was **1a) Bronchopneumonia; 1b) Oesophageal Granulation on the background of a Stent; 1c) Oesophageal Cancer (treated with chemo/radiotherapy)**
4	CIRCUMSTANCES OF THE DEATH Sandra Adina Lomax was diagnosed with oesophageal cancer in 2021. She was successfully treated with chemo/radiotherapy. She was referred to Tameside General Hospital for a post treatment endoscopy. In December 2021 an endoscopy identified a tight pinhole stricture. A stent was inserted as it was suspected that there was a perforation. The type of stent inserted required removal within 6 weeks in a case such as Mrs Lomax's. A combination of factors including clinicians not communicating effectively and no ownership of Mrs Lomax's case meant that the stent was not removed within 6 weeks. An attempt to remove the stent on 22nd March was unsuccessful because the stent was embedded due to the time that had elapsed since it was inserted. This was not urgently escalated although it was recognised this was a complex situation with potentially significant consequences for Mrs Lomax. She was scheduled to begin a complex stent removal process on 22nd June 2022. An operation at Salford Royal

	Hospital did not take place because the preoperative procedure was not followed. She had a series of bleeds in June 2022 that culminated with her being admitted to Stepping Hill Hospital on 19th June 2022. Her haemoglobin level was low. She developed pneumonia from the complications of the oesophageal granulation of the stent. She was treated with antibiotics but continued to deteriorate. She died at Stepping Hill Hospital on 25th June 2022.
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. The inquest heard evidence that the development of oesophageal strictures such as Mrs Lomax's was a relatively new development as a consequence of advances in chemo/radiotherapy that meant that surgery was not the only option for oesophageal cancers. However the management of theses strictures was complicated and there was no detailed national guidance on management of them and in particular when and how stenting should be approached. The development and implementation of detailed National Guidance was the inquest was told key to improving outcomes for patients such as Mrs Lomax across England; 2. Within Greater Manchester the inquest was told that the Christie were seeking to develop a specialist service for these complex cases but funding of a commissioned pan GM service was fundamental to a successful roll out that would benefit such patients as Mrs Lomax. The absence of such a service meant that cases such as Mrs Lomax's could arise going forward given that in most hospitals even experienced radiologists/gastroenterologists would have limited experience on how to manage such cases; 3. The inquest also heard evidence that to support management of cases such as Mrs Lomax there was a regular GM Upper GI MDT led by Salford Royal Hospital. However staffing issues meant that there was not a regular presence for all Trusts at the meeting. This impacted effective communication and impacted patient care; 4. This was compounded by the fact that the inquest heard evidence that the MDT did not have a system of effective communication of agreed actions and recommendations for individual patients discussed at the MDT. As a consequence local clinicians were unsighted as to the recommended way forward. The inquest was told that an effective and consistent pan GM approach to sharing the outcomes of MDTs would improve patient outcomes.

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 7th 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 namely 1) Mr Lomax on behalf of the Family; 2) Salford Royal Hospital; 3) Stepping Hill Hospital; 4) Tameside General Hospital; 5) The Christie NHS 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	**Alison Mutch OBE** **HM Senior Coroner**  **10.02.2023**