REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 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 28th December 2022 I commenced an investigation into the death of Marianne Erika Oldham. The investigation concluded on the 6th June 2023 and the conclusion was one of **Narrative: Died from the complications of a perforation of the sigmoid colon where the perforation was not identified until 12 hours after her arrival in the Emergency Department and treatment was delayed as a consequence.** The medical cause of death was **1a) Peritonitis; 1b) Stercoral Perforation of Sigmoid Colon; 1c) Intra-abdominal Adhesions; II) Ischaemic Heart Disease**
4	CIRCUMSTANCES OF THE DEATH Marianne Erika Oldham was admitted via ambulance to the Emergency Department at Tameside General Hospital on 16th December at 17:33. She was triaged at 17:52. She presented with a history of vomiting and abdominal pain. She was triaged into Category 3 (urgent) which recommends clinical assessment within 60 minutes. She was not clinically assessed until 02:46 - 9 hours after her arrival. The delay was due to the demand on the department and was not unusual at that time. The abdomen was distended and guarded. A decision was made that she needed antibiotics and a CT scan. The antibiotics were not prescribed until 04:21 and administered at 04:50. The CT scan was ordered at 04:13. The delay was due to the clinical demands on the department. The scan took place at 05:11 and at 05:44 it was reported on. The scan showed a sigmoid colon perforation. She was referred to the surgical team who saw her at 06:50. A conservative treatment plan was put in place. She was moved to a surgical ward where she began to rapidly deteriorate with her NEWS 2 score rising to 16 at 08:55. Her NEWS 2 had been 1 at triage and 3 at 23:53 and 04:13. She died at Tameside General Hospital on 17th December just after 9am from peritonitis.

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. – The inquest heard evidence that the very significant delay for Mrs Oldham to be seen by a clinician was due to the demand on Emergency Department Services. The inquest was told that delays of this length (9 hours) for patients who had been triaged to be seen within 60 minutes were not uncommon throughout the winter period across Greater Manchester and more widely. The demand was due to the volume of patients and the number of staff available to see and treat them. The delay was compounded by the shortage of radiographers and radiologists nationally meaning that even when a decision is taken for a scan it can take some time 9 an hour in this case) for it to take place and then reported on. In the time that Mrs Oldham was waiting to be seen she deteriorated very significantly meaning that by the time it was understood what the issue was she was very unwell and did not respond to conservative treatment which was all she was well enough for by that point.
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 14th September 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 [redacted] on behalf of the Family, 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** **HM Senior Coroner**  **20.07.2023**