	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Chief Executive, North Cumbria Integrated Care NHS Foundation Trust, Pillars Building, Cumberland Infirmary, Infirmary Street, Carlisle, Cumbria ,CA2 7HY.**
1	**CORONER** I am James Edward THOMPSON, HM Assistant Coroner for the Coroner area of Newcastle 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 5th April 2023 an inquest was opened into the death of Brian David MORETON. On 21st September 2023 I resumed the inquest. I concluded that Brian David MORETON died on 6th May 2022 at Freeman Hospital, Newcastle Upon Tyne from; 1a Cytomegalovirus colitis and invasive aspergillosis 1b Treatment of immune checkpoint inhibitor colitis 1c Immunotherapy for metastatic malignant melanoma I recorded a Narrative Conclusion together with a finding of Neglect.
4	**CIRCUMSTANCES OF DEATH** Brian Moreton was admitted to the Cumberland Infirmary on 2nd March 2022 with diarrhoea, recurring fever and a distended abdomen. A toxic mega colon was found on the evidence to have been present on CT imaging at that time, but was not reported to those treating him. He was treated over the following month with high dose immuno suppressants designed to treat a severe colitis without improvement. On 2nd April 2022 he was transferred to the Freeman Hospital, Newcastle Upon Tyne, where it was seen his bowel had perforated., He received surgery and remained very seriously ill. He developed various infections due to his immuno suppressed state and died from these infections on 6th May 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: - Evidence was heard that at the time of the inquest radiologists do not have access to patient' medical notes and base their reporting on a summary document submitted by the department requiring imaging. The summary document in Mr MORETON's case was seen to be deficient in that it omitted his symptom of fever. It was heard in evidence a radiologist would need to telephone the department in question or go there to inspect the notes. Their awareness of a patient's condition is based on a telephone call referral followed by a summary document which can be at odds with each. - It is of concern that the use of telephone referral system and summary could contain errors and the radiologist must rely on this information, with no quick way to inspect a patient's notes. - The evidence also dealt with radiologists working in 2 hour triage shifts in a hectic environment where those clinicians receiving the referral seldom were the clinicians who carried out the imaging. The inference was the arrangement was susceptible to error. - Over the course of the inquest evidence was heard on a number of issues where information passed to and from clinicians involved in Mr MORETON's care was inaccurate and misleading. - Assumptions were made that, Mr MORETON was improving clinically when a surgical opinion was sought, this was incorrect. - It was assumed Mr MORETON would be referred for a surgical opinion by ED department clinicians, when in fact none took place. - Clinicians in Newcastle Upon Tyne when asked for advice were under the impression treatment was working as it was mentioned his discharge from hospital was comptemplated - this was not the case. - Overall I am concerned by the poor and misleading communications between clinicians, departments and Hospital Trusts on matters of vital importance to patient care.
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 20th November 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: The family of Brian David MORETON via their solicitors Messrs Irwin Mitchell Chief Executive, Newcastle Upon Tyne Hospitals NHS Foundation Trust via their solicitors Messrs DAC Beachcroft Care Quality Commission 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** 25/9/23 **Coroner signature** P.R. Thyne