	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive, Northern Care Alliance NHS Foundation Trust, Mayo Building, Salford Royal, Stott Lane, Salford, M6 8HD**
1	**CORONER** I am Adrian Farrow, assistant 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 13th June 2023 an investigation was commenced into the death of Mary Margaret Horgan, aged 80 years. The investigation concluded at the end of the inquest on 6th August 2024. The inquest found that the medical cause of Mrs Horgan's death was: **1a) Severe Compressive Spinal Cord Injury** **1b) Traumatic Cervical Spinal Injury with Fracture Dislocation of the Cervical Spine.** The conclusion of the inquest was that she died from complications arising from a significant spinal injury sustained in an accidental fall.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Horgan fell at home on 5th May 2023. She was taken by ambulance to Wythenshawe hospital where a CT scan revealed no evidence of trauma to her neck or spine. However, she continued to experience pain to her neck and an MRI scan was attempted on 8th May to investigate further. Unfortunately, Mrs Horgan was unable to tolerate the procedure due to claustrophobia and anxiety on a background of bipolar affective disorder. No further attempt was made thereafter to mobilise Mrs Horgan, pending the MRI scan. By 11th May 2023, there were indications of spinal cord compromise, but these were subtle signs for which there were other possible credible alternative causes and the CT scan had shown no bony trauma. Although the plan was to continue to attempt to undertake an MRI scan, with sedation if necessary, due to pressures on the scanning equipment, no slot became available over the coming days. By 14th May, Mrs Horgan's breathing had become laboured, with hindsight, indicating a progression of spinal cord compression. The MRI scan was successfully achieved on 15th May. The radiological report failed to identify a dislocated fracture at C5/6 with spinal cord compression. In the light of the misleading report of the MRI scan, and weakness noted in Mrs Horgan's left arm, a referral was made via Patient Pass to the spinal team at Salford Royal Hospital at 19.10 hours. The Patient Pass system notified the on-call Registrar at the spinal unit of the new referral by text message and the Registrar triaged the referral, replying via Patient Pass to Wythenshawe hospital at 19.44 hours. Two minutes later, the Registrar contacted the on-call spinal Consultant. The evidence was that there is no alert generated by Patient Pass to the referrer to indicate that a reply has been generated. The spinal Consultant accessed the referral and the radiological scans, immediately identifying the C5/6 dislocated fracture and significant compromise of the spinal cord. By 20.36, there had been no response from Wythenshawe Hospital and the spinal

	Consultant posted another message on Patient Pass raising a number of questions seeking background information, highlighting the seriousness of Mrs Horgan's condition and advising that she be transferred as soon as possible to Salford Royal Hospital with and Aspen collar and spinal precautions. Further attempts by the on-call Registrar at Salford Royal Hospital to gain information from Wythenshawe Hospital by telephone were unsuccessful, in all likelihood because of a recent change of shift on the ward. Arrangements were made by the Wythenshawe Night Manager and the Salford Bed managers to transfer Mrs Horgan to Salford Royal by ambulance, but no collar or spinal precautions were deployed. By the time of the transfer, Patient Pass had not been accessed by the medical staff at Wythenshawe Hospital. The Patient Pass system was next checked at around 22.30 hours, by which time, Mrs Horgan had been taken to Salford Royal Hospital. The inquest heard that Patient Pass can only be accessed by medical staff with a General Medical Council registration number. The inquest also heard that the spinal unit at Salford Royal Hospital usually respond to new referrals within 30-40 minutes and in any event, a response can certainly be expected within an hour of the referral. The spinal unit regard all referrals via Patient Pass as urgent, hence the speed of the triage and initial response times. By contrast, the understanding of the medical staff at Wythenshawe is that Patient Pass is the only and routine method of referral for in-patients and there is no mechanism to indicate the receipt of a response or, if necessary, to differentiate between urgent and non-urgent referrals. On the part of the spinal unit at Salford Royal Hospital, from the evidence, it is anticipated that referrers would anticipate the swift response to a new referral, whereas there was no corresponding anticipation on the part of the medical staff at Wythenshawe Hospital of a need to expect a response within that timescale. Identifying and reading a response requires the referrer regularly to log in to Patient Pass to look for a response. The inquest heard that it may be possible for staff such as bed managers to obtain some information from the Patient Pass system, it was not directly accessible to them. The inquest also heard that it is possible to make bespoke amendments to the Patient Pass operations so as, for example, to give additional information about anticipated response times and contact numbers. It was also clear from the evidence that Patient Pass is widely used by a number of specialty units, whose working practices and utilisation of the Patient Pass system may differ. The inquest also heard that there is no specific induction training for junior doctors nor any refresher training for established doctors relating to the Patient Pass system within the established training programs. Once Mrs Horgan arrived at Salford Royal Hospital, it was clear that she was quadriplegic and that there was severe spinal compression. A further CT scan confirmed the dislocated C5/6 fracture. She was admitted to the Critical Care Unit. It was necessary to address low blood pressure in particular and having regard to her frailty and the poor response to blood pressure support, the decision was made, with Mrs Horgan and her family, that the risks outweighed any potential benefit of spinal surgery and palliative care was adopted. She was placed on end of life care and died on 5th June 2023.
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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – Whist the inquest found, on the evidence, that the transfer of Mrs Horgan between hospitals without an Aspen collar and spinal precautions as advised did not significantly contribute to her death, the obvious disparity revealed by the evidence between the two medical teams of their respective understanding and expectations of the way in which Patient Pass operates serves to create uncertainty and confusion and could easily give rise to a situation where the lives of patients may be put at risk.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation] 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 3rd October 2024. 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 [redacted], on behalf of Mrs Horgan's family and the Chief Executive, Manchester University NHS Foundation Trust, Cobbett House, Oxford Road, Manchester, M13 9WL. I have also sent a copy of my report to the Chair of the Greater Manchester Integrated Care Partnership, 4th Floor, 3 Piccadilly Place, Manchester M1 3BN and The Directors, Patient Pass Limited, Tomorrow Building, Media City UK, Salford, Greater Manchester, M50 2AB 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	**Adrian Farrow** **Hm Assistant Coroner**  **08.08.2024**