REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: [redacted], Chief Executive, Tameside and Glossop Integrated Care NHS Foundation Trust

CORONER

I am Chris Morris, Area Coroner for Greater Manchester (South).

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.
http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7
http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST

On 10th April 2024, Alison Mutch, Senior Coroner for Greater Manchester (South), opened an inquest into the death of Suzanne Rose Eccles who died on 3rd March 2024 at Tameside General Hospital, Ashton-under-Lyne, aged 72 years. The investigation concluded with an inquest which I heard on 13th September 2024.

The inquest determined that Mrs Eccles died as a consequence of:-

1) **a) Pneumonia and Empyema;**
b) Lung Cancer (operated 16th February 2024)

II Ischaemic Heart Disease

The conclusion of the inquest was a Narrative Conclusion, to the effect that Mrs Eccles died as a consequence of complications arising from necessary surgery which had not been identified in the course of previous hospital attendances.

CIRCUMSTANCES OF THE DEATH

Mrs Eccles died on 3rd March 2024 at Tameside General Hospital having developed Pneumonia and Empyema against a background of recent surgery for lung cancer. Her death was contributed to by Ischaemic Heart Disease. In the days leading up to her death, Mrs Eccles had been seen in the Same Day Emergency Care Unit and Emergency Department, and also been a patient on the Virtual Ward.

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. –

Whilst the court heard evidence as to significant work which has been undertaken following the Trust's detailed investigation into the circumstances leading to Mrs Eccles's death, it is a matter of

concern that no system currently operates whereby clinicians working in the Emergency Department can easily access records made by colleagues working on the Virtual Ward.

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by **14th November 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner, Mrs Eccles's daughter and son-in-law, and the Trust's legal team.

I have also sent a copy to the Care Quality Commission and NHS Greater Manchester Integrated Care 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.

Dated: **19th September 2024**

Signature: Chris Morris, Area Coroner, Manchester South.