Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1. NORTH WEST ANGLIA NHS FOUNDATION TRUST

1 CORONER

I am SIMON MILBURN, Area Coroner, for the coroner area of Cambridgeshire & Peterborough

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 25 January 2023 I commenced an investigation into the death of Richard David ROE aged 75. The investigation concluded at the end of the inquest on 17 October 2024. The conclusion of the inquest was that:

Mr Roe underwent a pulmonary angiogram at Hinchingbrook Hospital in Huntingdon on 26.09.21. This revealed a pancreatic cyst. A subsequent CT scan on 11.10.21 identified a lesion in excess of 3cm in the tail of the pancreas. The reporting radiologist recommended the scan be reviewed by the Hepato-Biliary MDT but the scan was neither actioned nor viewed. Had it been viewed the scan would have shown the presence of pancreatic cancer. Mr Roe re-presented to Hinchingbrook Hospital in November 2022 and a subsequent CT scan revealed the presence of metastatic pancreatic cancer. Sadly Mr Roe died at his home address, [redacted], at 0832hrs on 20.01.23.
Had his pancreatic cancer been identified in October 2021 it is likely that Mr Roe would have undergone surgery and been treated with subsequent chemotherapy. Although the chance of the treatment being curative was low had treatment been provided he would not have died as soon as 20.01.23.

4 CIRCUMSTANCES OF THE DEATH

Mr Roe underwent an abdominal CT scan in October 2021. This showed evidence of pancreatic cancer. The CT scan was the subject of a routine referral by the reporting radiologist due to the fact that an earlier pulmonary angiogram had identified a pancreatic cyst(so it was not flagged as an 'unexpected finding').
The CT scan was not reviewed or actioned as requested by the radiologist.
A subsequent CT scan conducted on 01.12.22 revealed that the pancreatic cancer had metastasised. Mr Roe died on 23.01.23.

5 CORONER'S CONCERNS

During the course of the investigation my inquiries 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:

	(1) The evidence revealed that there is currently no method for ensuring that routine CT scan reports are reviewed by clinicians. This is despite a similar occurrence in May 2021. The inquest heard that the Trust are investigating a new IT System which will be able to flag when such issues occur. However this is a medium/long term project with no current completion date known and there is no system in place at present to prevent a repeat of such an incident.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 December 17, 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; Mr Roe's Family/Legal Representatives I have also sent it to the Integrated Care Board who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	**Dated: 22/10/2024** **Simon MILBURN** **Area Coroner for** **Cambridgeshire and Peterborough**