REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: Secretary of State for Health & Social Care

1 CORONER

I am James Thompson, HM Assistant Coroner for Gateshead and South 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.

http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7

http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

3 INVESTIGATION and INQUEST

On 4th December 2023 I commenced an investigation into the death of John James JOHNSON. The investigation concluded at the end of the inquest. The conclusion of the inquest was –

John James Johnson died on 22nd November 2023 at the Queen Elizabeth Hospital, Gateshead from pneumonia. This has developed as a consequence of the development of squamous cell carcinoma of the right lung. These are both naturally occurring diseases running their full course resulting in his death.

The cancer was first detected on his admission to hospital in April 2022, but this finding was not investigated or any treatment commenced.

Upon presenting to hospital in May 2023, the cancer had progressed significantly and treatment options to cure the cancer were not available. Treatment designed to prolong his life were commenced, but he suffered a period of deterioration in his condition due to the progression of the cancer and died as a result.

Natural Causes contributed to by neglect.

1a Pneumonia

1b Squamous Cell Carcinoma of the Right Lung

1c

II

4 CIRCUMSTANCES OF THE DEATH

Mr Johnston presented at the Emergency Department of the Queen Elizabeth II Hospital, Gateshead in April 2023 with a broken leg after falling off a ladder. As part of the investigations undertaken at this time was a chest x-ray which showed a suspicious solitary mass lesion 32mm in size in the right upper zone and at the base of the left lung field.

It was to the reporting radiographer as highly suggestive of an underlying malignancy. This finding was flagged in the report comments and with a red alert marker. The report was sent to the referrer who was in the ED Department of the hospital, however by this stage of Mr Johnson's care in the hospital he was in the care of the Orthopaedics Department and also it appears on balance he either had just left or was in the process of leaving the hospital on discharge. The referring clinician, as was ED practice filed the report on the basis the current treating department - Orthopaedics or others still involved in his care would review the report. This did not happen as on balance Mr Johnson was leaving or had left the hospital and their care by then. The red alert was ignored as it was assumed to related to the fracture not the suspected cancer.

Mr Johnson did not receive any follow up in relation to the X-Ray finding and then presented in May 2023 at the same hospital with pain and investigations at this time detected a large right sided lung mass invading the spine. Treatment options were limited by this stage due to the progression of the cancer and they were related to control of the cancer as opposed to its removal and cure.

He deteriorated and died on 22nd November 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 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. –

(1) During the course of my investigation I heard evidence of the Hospital Trust operating a variety of IT systems to document a patient's stay in hospital. There was not one system which contained all the information generated during a patient's stay in hospital including, but not limited to, test results. It required clinical users to switch between systems to gather all the necessary information and raised the potential risk of significant findings being overlooked. It also slows down clinical decision making and makes it more difficult to follow a patient's overall care.

(2) In Mr Johnson's case, the X Ray report was returned to a department not then involved in his care. The use of multiple systems can create a risk around safe transfers of care for discharge or handover.

(3) I was told this issue is not confined to one individual Trust and the use of multiple systems is widespread across the National Health Service. Their use is well known to the national NHS responsible bodies.

(4) The Trust in question, has undertaken significant work to make the multiple systems it uses as safe and effective as possible so far as they are able to within their effective control.

(5) Given my concerns are not confined to the operations of one NHS Trust, this appears to be a risk that may be present nationally.

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 1st July 2025. 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 Mr Johnson and the Gateshead Health NHS Foundation Trust.

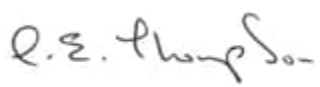
I am also under a duty to send the Chief Coroner a copy of your response.

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

6 May 2025

Signature



James Thompson HM Assistant Coroner for Gateshead & South Tyneside