

David Place Senior Coroner for the City of Sunderland

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO:
	South Tyneside and Sunderland NHS Foundation Trust
1	CORONER
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	I am David Place, His Majesty's Senior Coroner for the City of Sunderland
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 7 th March 2025 I commenced an Investigation into the death of Mrs Anne Lorraine Dyson, who died in St Benedict's Hospice, Sunderland on 24 th February 2025 aged 68 years. The Investigation concluded at the end of the Inquest on 15 th August 2025.
	I gave a conclusion 'Natural causes contributed to by neglect.'
	The medical cause of death was: - Ia Non Small Cell Lung Cancer (Metastatic)
4	CIRCUMSTANCES OF THE DEATH
	Anne Lorraine Dyson died at St Benedict's hospice on 24th February 2025 having been diagnosed with metastatic lung cancer on 20th November 2024 despite being under investigation for lung disease since September 2021 and scans showing an increased growth from October 2023. An incorrect interpretation of a CT scan of 25th March 2024 led to a significant delay of many months in diagnosing a malignancy which had progressed to be terminal and could no longer be successfully treated.
5	CORONER'S CONCERNS
	During the course of the Inquest the evidence revealed a matter 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: –
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The evidence revealed that when Radiologists are asked to interpret a scan, the information they are provided with varies in quality and level of detail, and there is no consistent approach, with Radiologists often having to create their own medical history from previous scans and reports, if any have been undertaken.

I am concerned that the evidence was that such requests for interpretation are often focused to a specific area of concern with a limited background history provided, and that this can lead to confirmation bias or satisfaction of search by the Radiologist when providing a report.

The evidence indicated that Radiologists are not provided with a list or a summary of a patient's symptoms or health complaints which resulted in the scan being commissioned, nor are they provided with details of any new or changed symptoms that have occurred during the investigative period.

I am concerned that this has the potential to restrict the focus of the interpreter resulting in only limited aspects of the scan being interpreted - not the whole of the scan, meaning that potential diagnosis and treatment can then be significantly delayed, if something is missed.

I shall be glad to be told of any learning arising from this death and timescales and results of your review.

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 21st October 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: -

- Family and their Solicitors
- 4 Ways and their Solicitors and Counsel
- 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 Dated this 26th day of August 2025

Signature:

HM Senior Coroner for the City of Sunderland