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 York and Scarborough Teaching Hospitals NHS Foundation Trust**
1	**CORONER** I am Catherine CUNDY, Area Coroner for the coroner area of North Yorkshire and York
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 30 July 2025 I commenced an investigation into the death of Pamela Ann HONEYBONE aged 90. The investigation concluded at the end of the inquest on 23 September 2025. The conclusion of the inquest was that: Pamela Ann Honeybone died as a consequence of naturally occurring disease. Diagnosis of her condition was delayed when another patient was scanned in error instead of Mrs Honeybone, but it has not been possible to determine on the balance of probabilities that this contributed to her death.
4	**CIRCUMSTANCES OF THE DEATH** On the 19th of September 2024 Pamela Ann Honeybone was admitted to Scarborough General Hospital following a fall. She required CT scanning but another patient with the same first name underwent the investigation in error and its results were attributed to Mrs Honeybone. Mrs Honeybone's condition continued to deteriorate and a CT scan undertaken on the 15th of October 2024 revealed the presence of an abdominal mass suggestive of lymphoma. Mrs Honeybone was moved to end of life care and she died at the hospital on the 19th of October 2024.
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: (brief summary of matters of concern) 1. It was accepted in evidence that neither the doctor who escorted the wrong patient from the Emergency Department to radiology, nor the radiographer who undertook the CT scan on her, checked the identity of the patient in question. No transfer checklist was completed, and the patient was not asked to complete and/or sign the CT scanning questionnaire herself. No member of staff inquired as to the outcome of this patient's CT scan prior to her discharge a few hours later. 2. The scanning error was recognised by a radiologist on the 15th of October 2024, but was not conveyed to Mrs Honeybone's treating team until late October, by which time she had

	died and her death had been scrutinised by the Medical Examiner and certified by her treating doctor as wholly natural and not requiring referral to the Coroner. 3. As a result of the delay at 2 above, a Trust investigation did not commence until late November 2024. No prompt after action review therefore occurred in the hours and days after the error was recognised. When the Trust investigation did commence, staff directly involved either could not be identified or had no recollection of events. 4. Despite hearing evidence that it was a doctor who would have escorted the wrong patient to scanning, the Trust Investigation focussed on nursing involvement with the patients in question and did not seek to identify and question medical team members. 5. An Action Plan was drawn up as a result of the Trust Investigation, but for various reasons no audit of compliance with patient identification processes commenced until early August 2025, some ten months after Mrs Honeybone's death. The results of the audit thus far were made available to me at inquest and indicate that 1 in 5 audited treatment encounters between staff of all grades and specialisms still occur without the patient being positively identified. 6. I heard evidence that while radiology transfer checklists are routinely completed 'in hours' at Scarborough Hospital when a dedicated HCA is on duty to perform this task, no such checklist is in use at the Trust's York site at any time of the day. Mrs Honeybone's misidentification occurred 'out of hours' at Scarborough when no designated person assumes responsibility for this task at that site. 7. I consider the above represent a continuing risk to others from misidentification and delayed responses to identified errors, with clear implications for patient safety.
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 November 19, 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 [redacted] I have also sent it to **Department of Health & Social Care - Prevention of Future Death Reporting** 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: 25/09/2025** [redacted] **Catherine CUNDY** **Area Coroner for** **North Yorkshire and York**