	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Chief Executive Officer, Tameside and Glossop Integrated Care NHS Foundation Trust, Silver Springs, Ashton-under-Lyne, OL6 9RW**
1	**CORONER** I am Adrian Farrow, assistant coroner, for the coroner area of Greater Manchester South
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 28th February 2025 an investigation was commenced into the death of Winifred Mary Wardle, aged 88 years. The investigation concluded at the end of the inquest on 15th July 2025. The conclusion of the inquest was that the medical cause of death was: 1a. Respiratory Failure 1b. Aspiration Pneumonia 1c. Incarcerated Hernia II. Ischemic Heart Disease, Frailty; and that Mrs Wardle died from complications from lung infection caused by aspiration immediately prior to necessary hernia repair surgery.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Wardle was admitted to Tameside General Hospital on 9th January 2025 at the instigation of her GP, suffering from dark brown vomiting and was initially suspected to have had and was treated for an abdominal bleed. However, a gastroscopy undertaken on 12th January 2025 with associated blood tests indicated an intestinal issue. A CT scan was deemed to be necessary by the treating doctors to diagnose the issue on 13th January 2025, but the CT scan was not performed until 17th January 2025. I heard evidence from a consultant physician and gastroenterologist that the process of obtaining a CT scan first required assessment by the on-call radiologist. In Mrs Wardle's case, the radiologist declined the request in favour of an abdominal x-ray to investigate for constipation. The x-ray was undertaken on 14th January and was inconclusive, by which time, blood tests revealed raised inflammatory markers and worsening condition which were indicative of the as yet undiagnosed incarcerated hernia. Although the CT scan was re-requested, the CT scan facility for Mrs Wardle was next available on 17th January. The evidence was that there was uncertainty about the communications between the ward and the radiology department as to the discussions during the period between the first request for the scan and the agreement by the radiology department to carry it out. The scan undertaken on the 17th January revealed the incarcerated hernia. The evidence at the inquest was that although it was possible for the treating doctors to speak directly with the radiologists there is a perception that a request for a CT scan by the surgical team carried more weight than a ward-level request. However, the evidence I heard was that the surgical team is keen to have the results of scans before accepting a patient for surgery. The result is that the decision as to whether and when a CT scan is undertaken rests with the on-call radiologist. Mrs Wardle suffered an episode of vomiting during the anaesthetic procedures on 18th January 2025. The operation was surgically successful, but Mrs Wardle had aspirated stomach contents immediately prior to the operation from which pneumonia developed. She required a prolonged stay in hospital and that, together with the debilitating effects of the hernia, her underlying co-morbidities and the surgery itself left her unable to breathe

	independently. Her condition did not improve sufficiently and active treatment was withdrawn. She died on 19th February 2025. The evidence at the inquest was that earlier surgery would have been beneficial in surgical terms, but that surgery could not be undertaken before the CT scan definitively diagnosed the incarcerated hernia. It was not possible to say whether the delay in diagnosis was causative of Mrs Wardle's death.
	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 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) There appears to be an absence within the Tameside General Hospital of a clear protocol for a multi-disciplinary approach to CT scan requests; (2) The on-call radiologist appears to be the ultimate decision-maker in relation to CT scan requests, even where ward-level doctors require urgent clarity from CT scans to achieve a diagnosis; (3) The lines of escalation where a request for a CT scan is not accepted by the radiology department are not clearly known or understood at ward-level, even by consultants; and (4) The records of the decision-making process concerning CT scan requests are not comprehensive so as to provide a clear account.
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 16th February 2026. 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 [redacted] on behalf of Mrs Wardle's family. 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 other 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.
9	**22nd December 2025**

	 **Adrian Farrow**