REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

1.	**CORONER** I am Jyoti Gill, Assistant Coroner, for the coroner area of Manchester South.
2.	**DATE OF REPORT** **17 June 2026**
3.	**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.	**THIS REPORT IS BEING SENT TO:** 1. Chief Executive of Tameside General Hospital 2. Secretary of State for Health and Social Care You are under a duty to respond to this report within 56 days of the date of this report, namely by 12 **August 2026**. I, the coroner, may extend the period if an appropriate application is made.
4.	**YOUR RESPONSE** 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.

5.	**SUMMARY OF CORONER'S CONCERN** The **MATTERS OF CONCERN** are as follows. – (1) My first concern relates to the implementation / development of the system doctors use in hospitals to access GP information. I heard in evidence that entries are vast on this system and that it is not easily discernible to find information in relation to a patient's vaccination status. I heard in evidence that a separate vaccination tab would be useful. I was also notified that work is being carried out in respect of the triage system so that, when a wound related discriminator is selected, clinicians are prompted to review and document the patient's vaccination history. Whilst work is being carried out at local trust level I cannot be certain what the situation across other hospitals nationally is and so should be looked at more widely. (2) My second concern relates to the failure to accurately record documentation in relation to Mrs Kirkham at Tameside General Hospital. The doctor treating Mrs Kirkham on 26 February 2025 did not record what he thought her clinical diagnosis was in her medical notes, and there was no reference to providing Catherine with a tetanus booster which the doctor stated he was sure he had given at the time or a diagnosis of tetanus. There are also concerns about prescribing someone with oral antibiotics without doing a swallow assessment when someone presents to the Emergency Department with swallowing symptoms and a lock jaw. This led to Catherine experiencing a choking event when back home, without the possibility of being admitted and provided with antibiotics intravenously. (3) My third concern relates to hearing in evidence that there was not only a missed opportunity by the Emergency Nurse Practitioner at the Urgent Treatment Centre on 19 February 2026, and the doctor in the Emergency Department on 26 February 2026 in identifying Mrs Kirkham's vaccination status and diagnosing and providing her with treatment for tetanus, but that this also appears to be missed in the GP referral to the hospital. The GP confirmed to the Trust that it is not routinely administered within primary care largely due to limited stock held by GP surgeries and that standard practice would be to refer the patient to the Emergency Department for wound assessment and review, where tetanus vaccination can be provided if clinically indicated. If this is the case, then the importance of noting that tetanus is suspected or that a patient is being referred for this reason should be noted and highlighted by primary care practitioners.

	We heard in evidence that the earlier a tetanus vaccination is given, especially to someone who is not fully immunised, the more effective it can be. An expert instructed by the trust as part of their investigation stated that had Mrs Kirkham been admitted on February 26 and managed appropriately for tetanus (including debridement of wounds, appropriate IV antibiotics, tetanus immunoglobulin, and escalated/Level 2 care), she would have had a chance of recovery.
6.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
7.	**INVESTIGATION AND INQUEST** On 7 March 205, I commenced an investigation into the death of Catherine Kirkham, aged 82 years who died at Willow Wood Hospice. The investigation concluded at the end of a jury inquest on 23 April 2026. A jury inquest was required as tetanus is a notifiable disease. The jury reached a narrative conclusion that Mrs Kirkham died following complications arising from tetanus which was first diagnosed and treated following her third attendance at hospital. The medical cause of death was: **1a) Pneumonia** **1b) Tetanus** **II) Ischemic heart failure, COPD**
8.	**CIRCUMSTANCES OF THE DEATH** Catherine sustained an unwitnessed fall at her home address on 14 February 2025. She presented to her GP on the 19th February 2025, with wounds to lower limbs and a necrotic toe. She was referred to A & E, where she was seen by an Emergency Nurse Practitioner. Her wounds were cleansed and dressed. She was given antibiotics and referred to the District Nursing Team, however Mrs Kirkham's tetanus status was not checked, and a tetanus vaccination was not provided. On 26 February 2025, Catherine re-presented to the Emergency Department with lockjaw and difficulty swallowing. After examination and observations

	Catherine was given antibiotics for cellulitis. Tetanus was discussed and dismissed. Catherine was sent home, despite Mrs Kirkham's son raising the possibility of tetanus with the doctor in the Emergency Department. We heard that despite Mrs Kirham having difficulty swallowing she was prescribed her with oral antibiotics. On the 28th February 2025 Mrs Kirkham's daughter urgently tried to arrange a liquid form of the antibiotics from her GP as her mother's teeth were clenched and it was difficult to open her mouth. Mrs Kirkham's symptoms worsened, including difficulty breathing, so she returned to hospital by ambulance. Mrs Kirkham was admitted and diagnosed with tetanus, COPD, Sepsis and Pneumonia. This is the first time Mrs Kirkham was treated for tetanus. On the 1 March 2025 Mrs Kirkham suffered two heart attacks. Due to Mrs Kirkham's clinical condition deteriorating a decision was made to commence end of life care. On 4 March 2025 Mrs Kirkham was transferred to Willow Wood Hospice and died shortly thereafter.
9.	**CORONER'S CONCERNS** During the course of the inquest I heard evidence 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: The first concern relates to the accessibility and usability of systems used by hospital clinicians to access GP records. Evidence indicated that entries within these systems are extensive and not easily navigable, making it difficult to identify key information such as a patient's vaccination status. The absence of a dedicated vaccination tab was highlighted as a barrier. Although some local work is underway to improve triage systems—prompting clinicians to check and document vaccination history when wound-related issues are identified—there is uncertainty as to whether such improvements are implemented consistently across hospitals nationally. The second concern relates to deficiencies in clinical documentation and decision-making during Mrs Kirkham's care at Tameside General Hospital. Specifically, the treating doctor failed to record a clear clinical diagnosis and did not document the administration of a tetanus booster, despite later stating he believed it had been given. Further concerns arose regarding the prescription of oral antibiotics without conducting a swallow assessment in a patient presenting with swallowing difficulties and lockjaw. This omission contributed to a subsequent choking incident at home and prevented the opportunity for hospital admission and intravenous treatment. The third concern relates to missed opportunities across multiple points of care to identify tetanus risk and provide appropriate treatment. These include failures in the Urgent Treatment Centre, Emergency Department, and in the

	GP referral. Given that tetanus vaccination is typically administered in secondary care, it is essential that referrals clearly highlight suspicion of tetanus. Earlier intervention may have significantly improved the patient's chances of survival.
10.	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: 1. Mrs Kirhams family 2. Millgate Healthcare Partnership (GP Surgery) I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
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