**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).

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| 1. | **CORONER**<br><br>I am Anna Morris, Assistant Coroner for the Coroner Area of Greater Manchester South. |
| 2. | **DATE OF REPORT**<br><br>10th June 2026 |
| 3. | **CORONER'S LEGAL POWERS**<br>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**<br><br>1.Tameside & Glossop Integrated Care NHS Foundation Trust<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 5th August 2026. I, the coroner, may extend the period if an appropriate application is made. |
| 4. | **YOUR RESPONSE**<br>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.<br><br>I have a duty to send a copy of your response to the Chief Coroner.<br><br>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.<br><br>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.<br><br>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. |

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| 5. | **SUMMARY OF CORONER'S CONCERN**<br><br>1) Mrs. Marland's deterioration and death followed an error in not escalating the abnormal blood results that were available for clinical review during her admission to Tameside Hospital on 7th November 2025.<br>**2)** Key aspects of the PSII action plan that are intended to mitigate the risk of future deaths are yet to be implemented by the Trust. |
| 6. | **ACTION SHOULD BE TAKEN**<br>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**<br><br>On the 4th November 2025, I commenced an investigation into the death of Judith Marsland. The investigation culminated in an inquest on the 9th June 2026. At the inquest, I found that Mrs. Marsland's medical cause of death was -<br><br>1a) Urosepsis and congestive cardiac failure<br>1b) Ischaemic heart disease<br>1c) Severe coronary arterial atherosclerosis<br><br>II Chronic kidney disease stage 3, hypertension, chronic obstructive pulmonary disease.<br><br>On the 9th June, I returned a narrative conclusion at the inquest which found that Mrs. Marsland died at Tameside Hospital on the 14th November 2025 from the complication of sepsis, which developed from a urinary tract infection which had likely been present since at least the 6th November 2025, and having been discharged from the hospital on the 7th November during which time an infection was not identified or treated. |
| 8. | **CIRCUMSTANCES OF DEATH**<br><br>Mrs. Marsland had a medical history which included heart failure and chronic kidney disease. In the 12 months prior to her death, she was treated for multiple urinary infections. It is likely that on or around the 6th November 2025 she was suffering from a urinary infection. On the 7th November Mrs. Marsland attended A&E at Tameside General Hospital and reported worsening intermittent bleeding and abdominal pain.<br><br>In the emergency department sepsis was considered but she was not managed on a sepsis pathway. Mrs. Marsland was transferred to the gynaecology hub for further review. Blood results that indicated acidosis and |

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| | elevated inflammatory markers were not reviewed and acted upon by the gynaecology clinical team. As a result, Mrs. Marsland was discharged from hospital and was not prescribed antibiotics.<br><br>On the 12th November, Mrs. Marsland attended A&E with an increase of pain. Clinical assessment identified septic shock with multiorgan failure, and she was commenced on antibiotics. Her condition deteriorated and Mrs. Marsland died in hospital on the 14th November 2025. |
| 9. | **CORONER'S CONCERNS**<br>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.<br><br>The **MATTERS OF CONCERN** are as follows:<br><br>3) I heard evidence from [redacted], the lead investigator from the Trust PSII that Mrs. Marland's deterioration and death followed an error in not escalating the abnormal blood results that were available for clinical review during her admission to Tameside Hospital on 7th November 2025. The PSII concluded that all blood results should have been reviewed and acted upon by the clinical teams that saw Mrs. Marsland and that she should not have been discharged home.<br><br>4) [redacted] evidence was that key aspects of the PSII action plan that are intended to mitigate the risk of future deaths are yet to be implemented by the Trust. In particular addressing the need for a structured cross-team handover from ED to speciality departments capturing clinical concerns, abnormal results, escalation plans, and creating named responsible clinicians. |
| 10. | **COPIES AND PUBLICATION OF THIS REPORT**<br><br>I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it.<br><br>I also may send a copy of the report to any other person who I believe may find it useful or of interest.<br><br>I can confirm I have sent the report to:<br><br>1. Mrs. Marsland's Family<br>2. The Millgate Healthcare Partnership<br><br>I also have a duty to send a copy of the report to the Chief Coroner. |

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| | 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. |
| | **SIGNATURE**<br>[redacted] |