



Tameside and Glossop
Integrated Care
NHS Foundation Trust


Chief Executive Officer
Tameside Hospital
Ashton-under-Lyne
OL6 9RW

08 October 2026

Strictly Private & Confidential

To be opened by the addressee only
HM Coroner
Coroner's Court
1 Mount Tabor Street
Stockport
Cheshire
SK1 3AG

Dear HM Coroner

Patient: Ms Paula Ivers
Date of Birth: 09.02.1977
Date of Death: 08.03.2024


Firstly, on behalf of the Trust, I would like to express my sincere condolences to Ms Iver's family for their loss.

The Trust acknowledges the concerns raised during the course of the inquest around key familial history not automatically being captured by the initial contact with the clinician and patients who present to the Trust with chest pain do not routinely have their blood pressure checked in both arms as a matter of course. These concerns will be addressed below.

Learning has been reinforced regarding the importance of obtaining and documenting a relevant family history at the earliest patient and clinician contact. Early identification of a family history of significant conditions, including cardiovascular disease, aortic disease, sudden cardiac death, thrombotic disorders, and inherited conditions, can provide valuable diagnostic information and influence clinical decision-making. Brief

family history is captured at the point of triage in the Emergency Department (ED) and that triage form is then reviewed by the clinician during their patient review. A full history, including significant family history, forms part of the clinical consultation. This supports a more comprehensive evaluation of patient risk factors, assists in the identification of potentially serious underlying pathology, and promotes timely investigation and escalation where appropriate. The Trust now also have in place an ED chest pain streaming pathway which takes into account the clinical review and the patients' presentation to ensure that the patient receives the right care in the right place.

The Trust also have access to the Greater Manchester Care Record (GMCR) which is a shared digital health and social care record used across Greater Manchester. It brings together information from NHS and care organisations into one secure record so that health and care professionals can access the information they need to provide safer and more coordinated care. It includes information such as current health conditions and diagnoses, medications, allergies, test results, care plans, mental health information, social care information and information provided by patients and carers through the "My GM Care" application. Access is limited to authorised health and social care professionals involved in a person's care for example GPs, hospital clinicians, community health teams, mental health services, social care staff and ambulance services and other specialist NHS services.

The GMCR was developed to improve patient safety, reduce the need for patients to repeat their medical history, enable faster and better informed clinical decisions, improve coordination between organisations and support integrated care across Greater Manchester. The GMCR covers nearly the entire Greater Manchester population, connecting hundreds of GP practices and health and care organisations across all ten Greater Manchester boroughs. It is used by thousands of frontline staff each month to support patient care.

Within the Trust, our clinicians can view important information diagnoses, medications, allergies, test results, care plans and recent contacts with other services without needing to contact multiple organisations. This can be particularly valuable in emergency and out-of-hours settings. Staff must complete role-appropriate training and be authorised to access the system as part of their professional duties. Extensive training has been rolled out across the organisation on the use of GMCR. In addition to GMCR training, staff also complete Information Governance training, Data Security Awareness training/Cyber security training and specific electronic patient record

training. The Trust has continued to strengthen its utilisation of GMCR to improve access to patient information. This enables clinicians to view relevant records held by NHS and GP organisations, supporting more informed clinical decision-making, improved communication between services and enhanced continuity of care.

We are continually working to improve the Trust documentation and we have carried out a sample audit in SDEC of random sample of 10 patients for the months of June, July and August. This audits measures against GMC expectation for accuracy, clarity, timeliness, relevance, confidentiality and support for care and includes documentation around familial history. The below table demonstrates the results of the audit which you can see supports an improvement:

	JUNE (%)	JULY(%)	AUGUST(%)
accuracy	100	90	100
clarity	100	90	100
Timeliness	100	90	100
relevance	70	80	80
confidentiality	100	100	100
Support of care	80	80	80
Compliance	91.6%	88.3%	93.3%

In SDEC, clinical assessments are now all electronic, whereas previously and at the time of Ms Iver's attendance, it was paper based. Clinical assessment, differential diagnosis and family history is now a compulsory field and progression on the electronic system cannot be actioned until this is completed. These compulsory fields are checked by the treating clinician and verified for accuracy. It is these compulsory fields that generate the discharge letter and actions for the GP which are now auto populated at the top of each discharge letter. Embedding this practice within routine clinical assessment has improved the quality of clinical documentation, supported earlier diagnosis, and ultimately improved patient safety and outcomes.

The Trust has also introduced an ED chest pain assessment pathway that provides a more structured and standardised approach to the assessment and management of patients presenting with chest pain. This pathway included blood pressure (BP) to be taken in both arms. Therefore, when a patient with chest pain is examined, bilateral BP is undertaken. The pathway supports patients' presentation, age, how long they have had chest pain and the treatment options, while facilitating the safe and timely streaming of low-risk patients to the Trust's medical SDEC. This went through the Trust's governance processes, ratification and was disseminated in June 2026. I have attached a copy of that pathway for your consideration.

Key learning from this inquest has been disseminated Trust wide including the importance of comprehensive clinical assessment, timely investigation, and clear documentation of clinical decision-making. The introduction of the pathway promotes consistent practice across the department, supports earlier access to diagnostic testing where indicated, and strengthens escalation processes for patients with concerning features. This learning has been shared with clinical staff to support safe and effective adoption of the new process.

The Trust acknowledges the concerns identified during the inquest and has taken the opportunity to strengthen both clinical areas to enhance continuity of care, support timely and informed decisions and contribute to patient safety by introducing electronic records for SDEC and clear streaming pathways which will continue to be monitored through the Trust's audit process.

I do hope that this letter provides you with further reassurance, however, should you have any queries arising from the content of this letter or require further information or clarification, please do not hesitate to contact Legal Services on [REDACTED]

Yours sincerely



Chief Medical Officer and Caldicott Guardian
On behalf of [REDACTED] (Chief Executive Officer)
Tameside and Glossop Integrated Care NHS Foundation Trust