

**RESPONSE TO A REPORT TO PREVENT FUTURE DEATHS
REGULATION 29 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 \(2026\)](#).

THIS RESPONSE IS BEING SENT TO:

The Assistant Coroner, Christopher Murray for the Coroner Area of Manchester South in response to a 'REPORT TO PREVENT FUTURE DEATH REGULATION 28' following an inquest into the death of Margaret Murphy that concluded on 21 July 2026.

1.	RESPONDENT In line with our duty under Regulation 29 of the Coroners (Investigations) Regulations 2013, NHS Greater Manchester Integrated Care Board provides this response within 56 days (plus any extension granted) of the date of the Report to Prevent Future Deaths.
2.	DATE OF RESPONSE 1 October 2026
3.	Thank you for the Regulation 28 Report sent to NHS Greater Manchester Integrated Care Board (NHS GM). I would like to say how sad we were to hear about the death of Ms Murphy and offer my sincere condolences to her loved ones. Thank you for highlighting your concerns following the inquest. I wanted to take the opportunity to respond to the matter of concern below that falls within our remit. CONFIRMATION OF CORONER'S MATTERS OF CONCERN The MATTER OF CONCERN is as follows: The court heard evidence that Tameside Hospital relies on an off-site laboratory to undertake and report on microbiology tests such as blood cultures. Whilst not a relevant factor in Ms Murphy's case, I am concerned as to the impact this system has on the time it takes relevant results to reach treating clinicians.
3.	DETAILS OF ACTION TAKEN NHS GM recognises the importance of ensuring that microbiology services support the timely diagnosis and treatment of patients. NHS GM has reviewed the concern raised by the Coroner and considered the response provided by Tameside and Glossop Integrated Care NHS Foundation Trust. The Trust has outlined a number of actions already undertaken in response to the concern, including review of the service level agreement governing

	microbiology services, audit work relating to blood culture processing and reporting, and ongoing work with Manchester University NHS Foundation Trust to strengthen arrangements and provide further assurance regarding turnaround times and escalation processes. NHS GM has reviewed the actions identified by the Trust and notes the planned implementation of a new laboratory information management system, together with the ongoing review of governance, reporting and escalation arrangements. NHS GM is satisfied that the Trust has recognised the concerns identified by the Coroner and has undertaken work to review the associated risks and identify opportunities for improvement.
4.	DETAILS OF FURTHER ACTION PROPOSED NHS GM will continue to seek assurance through its existing quality, commissioning and contract management arrangements regarding the implementation of actions identified by the Trust. NHS GM will continue to monitor progress through established oversight arrangements and review any further actions or learning arising from the Trust's ongoing work in this area.
	Thank you for bringing these matters to my attention. I hope the above provides assurance regarding the actions taken and planned in response to the concerns raised. Please do not hesitate to get in touch if you require any further information.  Deputy Chief Clinical Officer (Nursing and Nurse Advisor to the Board) NHS Greater Manchester