

**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 Miss Laurinda Bower, HM Area Coroner, for the coroner area of Nottingham City and Nottinghamshire.
2.	DATE OF REPORT 17 August 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.
4.	THIS REPORT IS BEING SENT TO 1. The Medical Director, Nottingham University Hospitals (NUH) NHS Trust You are under a duty to respond to this report within 56 days of the date of this report, namely by October 12, 2026. I, the coroner, may extend the period if an appropriate application is made.
5.	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 .
6.	SUMMARY OF CORONER'S CONCERN

	1. A failure to have in place a clear policy identifying the clinician responsible for acknowledging and actioning incidental findings arising from ED imaging reports 2. An over-reliance on conserus alerts to identify and safety net incidental findings, and a lack of clarity of language in the Trust's Radiology Guidelines for the issuing of such an alert
7.	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.
8.	INVESTIGATION AND INQUEST On 13 May 2025 I commenced an investigation into the death of Gloria Joan MONTE, aged 79. The investigation concluded at the end of the inquest on 17 August 2026. The conclusion of the inquest was that: Gloria Monte died on 2 May 2025, at the City Hospital, Nottingham, as a result of cancer. There was a delay in diagnosis due to individual and systemic omissions in her medical care.
9.	CIRCUMSTANCES OF DEATH Gloria Monte died on 2 May 2025, at the City Hospital, Nottingham, as a result of cancer. There was a delay in diagnosing Gloria's cancer of approximately one-year. She had attended the ED following a fall in February 2024. She was admitted to ED where a chest x-ray and trauma CT was arranged. The provisional report of the scan identified traumatic injuries and a lung nodule (14mm) which was described by the radiologist as "...likely incidental but could be a primary lung tumour". The radiologist did not consider that the threshold for conserus alerting (new probable cancer) was triggered. The ED doctor noted the incidental finding and recorded the same in the records when referring the patient to Major Trauma, with the expectation that Gloria would be admitted under Major Trauma and referred to the lung nodule MDT by the admitting team. The major trauma doctor reviewed Gloria in ED and determined that she did not require admission. She therefore remained an ED patient and the ED team prepared her discharge summary (which mentioned the incidental nodule but again made no referral for MDT review).

	The GP was not tasked with actioning a referral or follow up. The discharge summary was not shared with the patient (either in hard copy or electronically through the NHS app). The nodule was never investigated. Various outpatient and inpatient reviews took place over the course of the year but without any speciality noting the reference to the nodule (and lack of review). Gloria attended her GP in February 2025 with chest symptoms. She was treated with antibiotics but when she failed to improve, her GP arranged an admission to hospital. There, chest imaging showed findings suspicious of lung cancer and comparison with the February 2024 imaging led to the conclusion that the nodule noted the year prior probably was cancer. If diagnosis had been achieved as expected in 2024, Gloria would have been counselled on the available treatment options. If she had accepted those options, it is possible that she may have lived for longer than she in fact did, but I have been unable to determine whether her life would probably have been extended because there are many variables to the success of, and side effects of, cancer treatment. The risk of incidental imaging findings being overlooked has been known about by NUH for years and appears on the Trust's risk register. There has been a long-standing failure to adequately mitigate this risk, and there is ongoing dispute about who is responsible for actioning incidental imaging findings; ED (as the investigation originator to whom the results/reports will always be sent) or the admitting team. There is further discussion about the extent to which lung nodules fall under the conserus radiology reporting criteria for new cancer.
10.	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: 1. A failure to have in place a clear policy identifying the clinician responsible for acknowledging and actioning incidental findings from ED imaging This prevention of future deaths report follows the report issued at the conclusion of the inquest touching the death of David Marriott, at which similar themes were explored. Gloria's death is a further example of the Trust's failure to have in place a clear policy on who holds responsibility for taking action following a report of incidental findings on imaging requested by ED teams. During the course of this inquest, I heard evidence that a draft SOP is currently

being considered which shall place responsibility not with the originator of the imaging request (to whom the report shall be sent) but with the admitting team. I heard evidence of concerns regarding this proposed course, based on the variables that exist once a patient is referred to a speciality and/or leaves ED.

I am concerned that there is a risk of future deaths presented by the current SOP in the following scenarios:

- a. A patient might be referred to a speciality by the ED doctor holding a mindset that the patient is going to be admitted, only to find that the speciality has not admitted the patient. Where does responsibility rest then? If the speciality is being requested to provide a specialist opinion relevant to their expertise (and out of hours this is likely to be an incredibly stretched junior doctor covering the wards/theatre, as well as ED admissions and the on-call phone), is it reasonable to expect the speciality to pick up and action incidental findings arising from imaging request by ED?
- b. A patient might be admitted by a speciality, only to find that they have a more urgent medical concern which requires urgent transfer to another speciality. Where does responsibility rest then?
- c. Despite referral to a speciality, the patient might self-discharge before being seen by the speciality or admitted if accepted. Where does responsibility rest then?

Ultimately, requests for investigations come with results, and those results need to be acknowledged and actioned in a timely and appropriate manner. NHSE guidance proposes that responsibility should rest with the originator. "The clinician who orders or requests the imaging test—known as the referrer—is fundamentally responsible for acknowledging, reviewing, and acting upon the results. In emergency care, when shift handovers occur or teams share workloads, the responsibility must be clearly delegated and tracked".

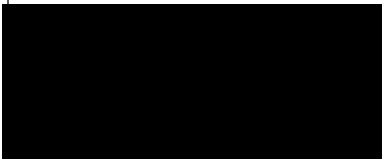
It is disappointing that locally our largest Trust has no agreed SOP to address this risk when NPSAs have been issued on this topic consistently since 2007.

2. An over-reliance on consensus alerts to identify and safety net incidental findings and a lack of clarity of language in the Trust's Radiology Guidelines

I heard evidence that there is a division of opinion amongst radiology colleagues as to whether a 14mm pulmonary nodule should trigger a cancer alert via consensus (there is agreement that it should be reported, of course).

The policy states "5.2 New cancer imaging expected or unexpected. This includes expected or unexpected imaging findings that suggest new or probable new cancer and new or probable new cancer recurrence within the report."

Later the policy provides a non-exhaustive list of examples, including, "An unexpected lung nodule or a solid renal mass suspicious of a new

	carcinoma" There are three different standards mooted within the guidance – suspected, probable and suspicious - which is unhelpful. Whether the threshold of suspicious applies only to a solid renal mass is also open for debate. In Gloria's case, the radiologist reported the nodule as "likely incidental but could be a primary lung tumour". The British Thoracic Society Guidelines (2015) identify pulmonary nodules of greater than 5-6mm as requiring follow up (the degree of action then increases based on size). In which case, might this be a clear trigger for an alert?
11.	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: IPs 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.
12.	SIGNATURE  Miss Laurinda Bower HM Area Coroner Nottingham