

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 Chris Morris, Area Coroner, for the coroner area of Greater Manchester (South)
2.	DATE OF REPORT 21 July 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) The Secretary of State for Health and Social Care; 2) The Chief Executive, Greater Manchester Integrated Care Partnership; and 3) The Chief Executive, Tameside and Glossop Integrated Care NHS Foundation Trust. You are under a duty to respond to this report within 56 days of the date of this report, namely by 15 September 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.
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5.	SUMMARY OF CORONER'S CONCERNS This report is made in respect of concerns arising from the evidence relating to provision of medical microbiology both nationally and locally, and record-keeping systems at Tameside General Hospital.
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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.
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7.	INVESTIGATION AND INQUEST On 17 December 2025, an inquest was opened into the death of Margaret Murphy who died at Tameside General Hospital, Ashton-under-Lyne on 9 October 2025, aged 82 years. A post mortem examination determined Miss Murphy died as a consequence of: 1)a) Multiorgan failure 1)b) Septic shock 1)c) Necrotising fasciitis of the right middle finger - II Chronic obstructive pulmonary disease, hypertension
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	The inquest concluded on 17 July 2026. At the end of the inquest, I recorded a Narrative Conclusion, finding that Miss Murphy died as a consequence of complications arising from undiagnosed necrotising fasciitis.
8.	CIRCUMSTANCES OF DEATH Margaret Murphy died on 9 October 2025 at Tameside General Hospital, Ashton-under-Lyne, as a consequence of multiorgan failure due to septic shock arising from necrotising fasciitis of the right middle finger. Miss Murphy's death was contributed to by chronic obstructive pulmonary disease and hypertension. Despite attending hospital on 4th, 5th and 6th October 2025 and ultimately undergoing amputation of her right middle finger, it was first identified Miss Murphy had developed necrotising fasciitis after she had died.

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:

To the Secretary of State for Health and Social Care

1. A consultant in medical microbiology gave evidence as to a national shortage of doctors of that specialism in the NHS. Given the significance of microbiology to modern medicine, I am concerned any such shortage creates a risk of future deaths.

To the Chief Executives of Greater Manchester Integrated Care Partnership and Tameside and Glossop Integrated Care NHS Foundation Trust

2. 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 Miss Murphy's case, I am concerned as to the impact this system has for the time it takes relevant results to reach treating clinicians.

To the Chief Executive of Tameside and Glossop Integrated Care NHS Foundation Trust

3. Having reviewed Miss Murphy in the Same Day Emergency Care Unit on 5 October 2025, the Orthopaedic Senior House Officer wrote their notes in a Trauma and Orthopaedic 'Tracker', not routinely accessible to clinicians working in other specialities. I am concerned as to the risk of future deaths which arises from the creation of an extra layer of documentation not easily visible to others in the hospital, particularly in the context of an already disjointed and labyrinthine system for capturing clinical information.

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: <i>[please do not use individual's names, but instead roles/titles]</i> 1) Miss Murphy's family; 2) Weightmans LLP; and 3) Care Quality Commission. 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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