REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: NHS England and NICE (National Institute for Health and Care Excellence)
1	CORONER I am Alison Mutch, Senior Coroner, for the Coroner Area of Greater Manchester South
2	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	INVESTIGATION and INQUEST On 16th September 2021 I commenced an investigation into the death of Raymond Lee. The investigation concluded on the 19th January 2023 and the conclusion was one of **Narrative: Died from complications of treatment for oesophageal cancer and a subsequent oesophageal stricture.** The medical cause of death was **1a) Gastrointestinal Haemorrhage; 1b) Aorta-oesophageal fistula on the background of oesophageal stent; 1c) Oesophageal cancer treated by radiotherapy**
4	CIRCUMSTANCES OF THE DEATH Raymond Douglas Lee had oesophageal cancer. Due to his underlying health, he was treated with radiotherapy- other treatments were not felt to be suitable. He developed an oesophageal stricture as a consequence of the radiotherapy treatment. Dilatation procedure did not lead to an improvement. A biodegradable stent was inserted to try to improve the position. He was in significant pain as a consequence of the stent. Pain is a recognised complication of stenting in these circumstances. He was admitted to Stepping Hill Hospital on 13th September 2021 following episodes of bleeding. A gastroscopy on 14th September 2021 confirmed that the bleeding was from the oesophagus - from an aorta/oesophageal fistula. On the balance of probabilities, the stent had contributed to the development of the fistula. Raymond Douglas Lee continued to deteriorate and died at Stepping Hill Hospital on 14th September 2021.

5	CORONER'S CONCERNS During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The MATTERS OF CONCERN are as follows. – The inquest heard evidence that oesophageal strictures are a recognised complication of radiotherapy for oesophageal cancers. The implications of them are significant for patients as they can lead to aspiration and as well as significantly impact quality of life. At this time there is only very limited national guidance on how to best treat patients with strictures and limited evidence on which to develop best practice. The evidence given was that careful dilatation by an experienced practitioner was the best approach initially. However, dilatation particularly repeated dilatation carried risk of perforation and needed to be seen as something that could not be continued indefinitely. However, there was limited evidence on what the optimum number of dilatations were and/or when to stop and move to consider stenting. The inquest heard that stenting of patients in these circumstances has a limited body of evidence regarding the risk. The inquest highlighted that perforation may be a risk in some cases where a stent is used and that needed to be factored into any decision to use a stent.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by 10th July 2023. I, the coroner, may extend the period. 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.
8	COPIES and PUBLICATION I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely 1) [redacted] on behalf of the Family; 2) [redacted] 3) The Christie NHS Foundation Trust; and 4) Stockport NHS Foundation Trust, who may find it useful or of interest. I am also under a duty to send the Chief Coroner a copy of your response.

	The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**Alison Mutch** **HM Senior Coroner**  **15.05.2023**