Regulations 28 and 29 of the Coroners' (Investigations) Regulations 2013

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Chief Executive of Aneurin Bevan University Health Board.
1	**CORONER** I am **Caroline Saunders,** Senior Coroner for the Area of Gwent
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 10/12/2020 an investigation was opened into the death of Maria Christine Shafighian The investigation concluded at the end of the inquest on: 6/4/2023 <u>The conclusion of the inquest was recorded as:</u> Death from Natural Causes <u>The medical cause of death was:</u> 1a. Metastatic oesophageal cancer.
4	**CIRCUMSTANCES OF THE DEATH** Maria Shafighian was a 59-year-old woman who was referred to the ENT department at Aneurin Bevan University Health Board by her GP on 27/1/2020 with symptoms of persistent hoarseness. Ms Shafighian was assessed by a specialist ENT trainee on 3/2/2020 who ordered a CT scan, which found no evidence of laryngeal cancer. Maria was diagnosed with vocal cord palsy and referred to the Speech and Language Therapists (SALT). On 4/5/2020 the SALT team noted that Maria was suffering from dysphagia which I heard was a worrying development which may need urgent

	assessment. I heard that the SALT team referred Maria back to the ENT team and notified them of this development. After further assessment, Maria was diagnosed with oesophageal cancer. She was not a candidate for surgical intervention and received palliative chemotherapy and radiotherapy. Maria Shafighian died from the effects of oesophageal cancer at Ysbyty Ystrad Fawr on 24/11/2020 In the inquest I determined that there had been opportunities missed to identify and treat Maria's tumour earlier but I could not determine on balance that this would have altered the outcome and hence the conclusion was death by natural causes.
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows: - During the inquest I heard that the process by which the SALT team notified the ENT department of the change in Maria's presentation and the development of dysphagia was through an internal postal system. Following assessment by SALT on 4/5/2020, a letter was written to the ENT team which was printed and left in a pigeon hole. No evidence was forthcoming to describe a system whereby urgent matters would be brought immediately to the attention of the referring team and there was no process for ensuring that the post was dealt with in a timely manner. In Maria's case there appears to have been a delay of a month between the letter being sent and being noticed by the ENT team.
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. <u>I should be grateful if the following information be provided to me:</u> Confirm the processes that are in place to ensure that changes in patients' presentation are brought to the attention of the appropriate clinical teams in a timely fashion and the policies which are in place to underpin the use of alert systems and the internal postal service.

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely 16 June 2023. I, the Coroner, may extend this 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 necessary
8	**COPIES AND PUBLICATION** I have sent a copy of my report to the Chief Coroner and the following Interested Person (s) • The family of Maria Christine Shafighian 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 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	**DATE 21/4/23** Signed Caroline Saunders **His Majesty's Senior Coroner for the Area of Gwent.**