REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: [redacted], Chief Executive, Stockport NHS Foundation Trust

CORONER

I am Chris Morris, Area Coroner for Manchester South.

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.
http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7
http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST

On 30th November 2022, I opened an inquest into the death of Christine Mary Dickinson who died on 15th November 2022 at Stepping Hill Hospital, Stockport, aged 76 years. The investigation concluded with an inquest which I heard on 16th June 2023.

The inquest determined that Mrs Dickinson died as a consequence of:-

1) a) Pneumocystis Jirovecii Pneumonia;
   b) Interstitial Lung Disease and Immunosuppression

   II) Lymphoma

The conclusion of the inquest was a Narrative Conclusion to the effect that Mrs Dickinson died as a consequence of recognised complications of prescribed medication in conjunction with the effects of interstitial lung disease and lymphoma.

CIRCUMSTANCES OF THE DEATH

Mrs Dickinson had been diagnosed with Grade II Follicular Lymphoma and had been receiving treatment at the Laurel Unit with Rituximab.

In August 2022, Mrs Dickinson was admitted to hospital with respiratory difficulties, and provisionally diagnosed with Hypersensitivity Pneumonitis which initially responded to treatment with steroids.

Following her discharge, Mrs Dickinson was administered with Rituximab on the Laurel Unit once more. In October 2022, Mrs Dickinson was admitted to hospital for the final time and became gravely ill, dying on 15th November 2022.

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. –

1. During the course of the inquest, the court heard evidence that staff on the Laurel Unit previously used a variety of systems (including one system not routinely accessible by staff elsewhere in the hospital) to record the administration of Chemotherapy.

2. Whilst the Consultant Haematologist told the court the requirement to use a single method of recording administration of Chemotherapy has be reinforced, in view of the above together with the fact that details pertaining to another patient entirely appear to have been entered into Mrs Dickinson's record from September 2022, it is a matter of concern that no recent audit has been undertaken in respect of record-keeping on the Laurel Unit.

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by **12th September 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner, Harvey Roberts Solicitors on behalf of Mrs Dickinson's family, and Browne Jacobson LLP on behalf of Stockport NHS Foundation Trust.

I have also sent a copy to the Care Quality Commission and NHS Greater Manchester Integrated Care 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.

Dated: **18th July 2023**

Signature: Chris Morris HM Area Coroner, Manchester South.