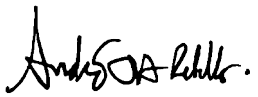
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Clatterbridge Cancer Centre (Liverpool)**
1	**CORONER** I am Andre REBELLO, Senior Coroner for the coroner area of Liverpool and Wirral
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 05 September 2023 I commenced an investigation into the death of Marjorie MCEVOY aged 64. The investigation concluded at the end of the inquest on 02 February 2024. The cause of death found was: 1a Gastrointestinal haemorrhage 1b Treatment for squamous cell carcinoma II Bronchopneumonia and Chronic Obstructive Pulmonary Disease The conclusion of the inquest was that: **Marjorie MCEVOY died from a misadventure namely a rare but recognised complication of treatment for cancer.**
4	**CIRCUMSTANCES OF THE DEATH** Mrs Marjorie McEvoy had a medical history of chronic obstructive pulmonary disease, Rheumatoid arthritis and Anal squamous cell carcinoma T2N1. She was on radical treatment with Capecitabine and Mitomycin for radical intent. The cycle commenced on 10/07/2023. Afterwards developed severe mucositis with led to her poor oral intake, diarrhoea and tongue swelling. She was seen by advanced nurse practitioners as well as consultant oncologists. She was admitted in hospital and given antibiotics, IV fluids and supportive care. She also presented Pancytopenia, which was more likely than not chemotherapy related. During admission developed a gastrointestinal bleed related to mucositis. She had multiple blood transfusions and investigations. She recovered initially however had further gastrointestinal bleed on 18th August 2023. She was certified as having died at 04.05 on the 21st August 2023. It is more likely than not that her severe reaction to the treatment was such that stopping the treatment was unlikely to have prevented her death. The quality of the clinical notation from advanced nurse practitioners did not put the oncology team in the best position to react to her care needs.

5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters 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: (Brief summary of matters of concern) During the course of this investigation it became apparent that the clinical notation by advanced nurse practitioners were inadequate in that they did not explain the patient's presentation to enable escalation of care. These notes should be to a similar standard as those of doctors.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) 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 March 29, 2024. 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 [redacted] I have also sent it to. **Chief Coroner (reg28)** **NHS England & NHS Improvement (PFDs)** who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner, and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	**Dated: 02/02/2024**

	 **Andre REBELLO** **Senior Coroner for** **Liverpool and Wirral**