Oxford University Hospitals
NHS Foundation Trust

[redacted]
Acting Chief Executive Officer
The John Radcliffe
Headley Way
Headington
Oxford
OX3 9DU
Tel: 01865 221383

02 June 2025

Your ref: [redacted]

Mr Guy Davies
HM Assistant Coroner for Cornwall & the Isles of Scilly Coroner's Area

Sent via email only to: [redacted]

Dear Mr Davies

Regulation 28 Report/Prevention of Future Deaths Letter
Inquest into the Death of Mrs June Thompson

Following the death of Mrs June Thompson and subsequent inquest hearing from 26 – 27 March 2025, I write as Acting Chief Executive Officer of Oxford University Hospitals NHS Foundation Trust (OUH), to provide a response to your Regulation 28 Report dated 6 April 2025.

I would like to start by expressing to Mrs Thompson's husband and family how sorry I am for their loss.

Mrs Thompson was referred to OUH by Royal Cornwall Hospital Truro (RCHT) on 2 June 2023 to consider a palliative hip replacement for presumed metastatic cervical adenocarcinoma of the right hip. She was seen in out-patient clinic at OUH on 19 June 2023 and had an ultrasound guided biopsy of her pubic ramus on 4 July 2023. This was reported on 12 July 2023 as showing a high-grade small cell/ spindle cell malignant tumour which was discussed at the Oxford Sarcoma MDT Meeting on 10 July 2023; the MDT recommended discussion with the RCHT Gynaecology MDT to compare the new histology with previous histology from 2019.

A referral was also made simultaneously to the OUH Gynaecology Oncology service with a view to seek an opinion about pelvic exenteration. Mrs Thompson attended OUH gynaecology clinic on 19 July 2023 where it was assessed that the oncology picture was unlikely to be a recurrence of cervical cancer. A whole body PET scan was planned

at OUH as well as recommended referral to the local Cornwall Pain Team and an ultrasound scan in Cornwall to exclude a Deep vein thrombosis.

Mrs Thompson had a CT angiogram at RCHT on 26 July 2023 to assess the cause of limb swelling which was thought to be vascular occlusion from the rapidly growing sarcoma in her hip. She also had a CT scan of her thorax, abdomen and pelvis on 26 July 2023. Mrs Thompson's case was further discussed at the OUH Sarcoma MDT Meeting on 31 July 2023. The decision was to proceed with a right hindquarter amputation for local control of aggressive disease. It was also noted that in the CT scan from 26 July there were at least 3 lung nodules, potentially metastases but considered to be indeterminate at that stage. It was noted on 31 July that Mrs Thompson was still awaiting a PET scan to determine the status of the lung nodules.

Mrs Thompson declined to have a PET scan on 1 August 2023 as she felt unable to tolerate the whole body scan. On 2 August 2023 the RCHT Gynaecology Nurse and OUH sarcoma nurse discussed the OUH MDT outcome with Mrs Thompson.

The CT angiogram scan from 26 July at RCHT had not been formally reported however the treating OUH orthopaedic sarcoma consultant surgeon reviewed the images on 7 August 2023 and saw for himself the venous occlusion and external compression of the artery by the tumour. The OUH treating consultant surgeon also noted some lung nodules on the CT angiogram images. The treating consultant surgeon assessed that hindquarter amputation was still indicated both for local control and due to threatened limb (impending vascular occlusion). At this stage the purpose of the surgery was still felt to be potentially curative as the status of the lung nodules was not certain as Mrs Thompson was unable to tolerate the PET scan.

On 9 August 2023 Mrs Thompson attended the OUH Sarcoma Specialist Pelvic Clinic and was admitted urgently for pain management, IVC filter and a new MRI to plan for proposed surgery. A new MRI of the pelvis and right lower leg was performed. She was also seen by the Occupational Therapy and Sarcoma Specialist Nurse teams in preparation for surgery. On 11 August 2023 the inferior vena cava filter was inserted and after optimising pain control, she was discharged until the planned surgical date of 23 August 2023.

On 15 August 2023 the report of the CT angiogram and CT chest, abdomen and pelvis performed on 26 July 2023 in Cornwall was emailed to the OUH Sarcoma administrative team. The report noted multiple new lung metastases, progressive right acetabular bony destruction, venous obstruction of right external iliac vein by tumour invasion, and grossly abnormal arterial supply to the lower limbs. The CT angiogram result was uploaded to the OUH Electronic Patient Record but not communicated to the treating Consultant Surgeon.

Mrs Thompson was admitted to OUH and proceeded to a right hindquarter amputation on 23 August 2023.

You recorded a narrative conclusion on 27 March 2025 as follows: “June (Thompson) died on 1 November 2023 at [redacted], Cornwall from Radiation Induced Metastatic Sarcoma, following radiotherapy treatment for cervical cancer”

The medical cause of death was confirmed after hearing evidence from Royal Cornwall Hospital clinicians, OUH clinicians and GP representative by you to be:

1a Radiation Induced Metastatic Sarcoma

In your conclusion you set out four areas of concern, and for each I can provide the following additional information outlining how we are addressing the concerns:

1. **There is a risk of future deaths from decisions to proceed with major operations without the surgical team having full knowledge of disease progression, this could include operations that may be unnecessary**

To address this risk across the Trust, a new Standard Operational Protocol (SOP) has been developed for *Management of Patient Related Clinical Information received from another Department / Trust / Organisations*. I **attach** a copy of this SOP which has already been implemented in the gynaecology and sarcoma services and is being rolled out across the Trust.

In addition, a separate SOP for the Oxford Radical Pelvic Surgical team has been revised to include a prompt to check for test result reports from external NHS Trusts before proceeding to treatment. If test results are requested within OUH then the Electronic Patient Record already automatically notifies the test requestor and the named consultant of the result. The updated SOP has been distributed to all pelvic surgical consultants and will be shared with Clinical Leads for Surgery for learning across the Trust. I **attach** a copy of this clinical SOP.

The learning from this inquest and the subsequent investigation (see below) was highlighted at the Trust wide Safety Learning and Improvement Conversation on 17 April 2025 and the key learning of communicating test and scan results performed outside OUH to the named consultant was included in the summary slide from this meeting which was circulated to all clinical teams. A Trust wide Patient Safety Message email highlighting the importance of reviewing all radiology reports prior to surgery has been drafted and will be circulated to all OUH staff in the next 4 weeks.

2. **The error has not been reported through the OUH Incident Reporting process**

We acknowledge that the incident was not reported in our incident reporting system until after the inquest. The Sarcoma service has an open and transparent reporting culture as evidenced by 37 incidents that have been reported in the last 2 years with 26 of these being of ‘no harm’. We have fed back to the team the importance of reporting any patient safety incidents and will send a Trust wide Safety Message emphasising the importance of reporting all safety incidents including ‘no harm’ (previously known as ‘near misses’) to ensure learning to prevent future harm.

3. **The error has not been investigated to establish why it happened and how to prevent a reoccurrence**

The incident has now been reported and investigated in line with the Trust's implementation of the Patient Safety Incident Response Framework. The learning from the inquest and this investigation has been highlighted at the Trust-wide Safety Learning and Improvement Conversation and circulated to all clinical teams. It will also be presented at the next Sarcoma Surgery Clinical Governance meeting, Trust Clinical Governance Committee and the OUH Mortality Review Group over the next 2 months.

4. **There is no policy, guidance or standard operating procedure regarding how to process medical reports being received at OUH from other hospitals.**

As summarised above, to address this risk across the Trust, a new SOP has been developed to ensure that any clinical information received by OUH from other NHS Trusts is shared promptly with all relevant clinicians, and the learning from this inquest has been highlighted at the Trust wide Safety Learning and Improvement Conversation and circulated to all clinical teams.

Thank you for bringing to our attention the issues above, which have allowed us to take action to address the risks you identified. I hope that this response reassures you that we have taken your concerns very seriously and implemented appropriate actions to prevent a similar incident happening in the future.

Yours sincerely

[redacted]

[redacted]

Acting Chief Executive Officer

Attachments:

1. New Gynaecology/Sarcoma Administrative SOP
2. Updated Oxford Radical Pelvic Surgery SOP