REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

IN THE MATTER OF THE INQUEST

TOUCHING THE DEATH OF JUNE THOMPSON

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] Chief Executive Officer, Oxford University Hospitals NHS Foundation Trust
1	**CORONER** **I am Guy Davies, His Majesty's Assistant Coroner for Cornwall & the Isles of Scilly.**
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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 9 November 2023 I commenced an investigation into the death of sixty-five-year-old June Thompson. The investigation concluded at the end of the inquest on 27 March 2025. The medical cause of death was found to be as follows. *1a Radiation Induced Metastatic Sarcoma* The four questions - who, when, where and how – were answered as follows *June THOMPSON died on 1 November 2023 at* [redacted] *Falmouth Cornwall from Radiation Induced Metastatic Sarcoma, following radiotherapy treatment for cervical cancer.* The conclusion as to June's death was as follows. *June died from recognized complications of necessary medical treatment.*

4	**CIRCUMSTANCES OF THE DEATH** 1) June died after a short illness following diagnosis of a very aggressive form of cancer in the hip which spread to the lungs. 2) June first presented with symptoms associated with her cause of death in January 2023 and was initially treated at Royal Cornwall Hospital Truro (RCHT) where a cancerous hip tumour was identified. 3) The rapid growth of the tumour meant that her case had to be transferred to Oxford University Hospital (OUH) for specialist surgery which was not available at RCHT. June required a hindquarter amputation, involving the removal of the whole leg and hip joint, the latter to include removal of the tumour from the hip. 4) This major surgery was originally proposed to June as being a curative operation. On this basis June consented to the operation, and the procedure was approved by the surgical Multi-Disciplinary Team (MDT). 5) Meanwhile RCHT continued to assist with scans and other treatments. A CT scan report conducted 26 July 2025 by RCHT indicated that the cancer had spread. The scan report showed multiple new lung metastases. The cancer in the lungs was of such an extent that it was not operable or treatable. 6) June's clinical condition had now changed from being curative to palliative. 7) The 26 July RCHT CT scan report was sent to OUH and uploaded to the OUH digital file on 15 August 2025. The scan report was not directly emailed to the OUH surgeon. 8) The operation went ahead on the 23 August 2023. June's leg was amputated and the tumour in the hip removed. 9) The surgeon stated that at the time of the operation he was not aware that June's clinical condition had changed from curative to palliative. The surgeon stated that his attention was drawn to the CT scan report after the operation. 10) The surgeon had operated on the false basis that this was a curative operation. 11) The patient June had consented to the operation on the false basis that this was a curative operation. 12) The MDT had supported the decision to operate without being informed of the change in clinical condition. 13) June suffered a number of complications after the amputation and required two further operations to deal with these issues. June was not discharged from hospital until 20 October 2023 when she returned home to die with her family on 1 November 2023.
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. –

	• 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. • The error has not been reported through the OUH Incident Reporting process. • The error has not been investigated to establish why it happened and how to prevent a reoccurrence. • There is no policy, guidance or standard operating procedure regarding how to process medical reports being received at OUH from other hospitals.
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 2 June 2025. 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: the family, RCHT. GP [redacted]. 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	**6 April 2025** **HMC Guy Davies**