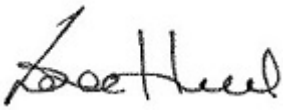
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • **University Hospitals Birmingham NHS Foundation Trust** • **Secretary of State for Health** • **Birmingham and Solihull Integrated Care Service**
1	**CORONER** I am Louise Hunt, HM Senior Coroner for Birmingham and Solihull
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 2 September 2024 I commenced an investigation into the death of Tina Louise DOIG. The investigation concluded at the end of the inquest . The conclusion of the inquest was; Her death was a consequence of a serious underlying blood cancer which progressed to acute myeloid leukaemia contributed to by sepsis due to prolonged immunosuppression, a failed first stem cell transplant caused by a failure to undertake appropriate testing on the donor and recipient before transplant and a subsequent Stem cell transplant.

4	**CIRCUMSTANCES OF THE DEATH** **Mrs Doig was diagnosed with myelodysplasia (a rare blood cancer) in September 2023. She had an aggressive haematological condition with high-risk features and was at risk of developing acute myeloid leukaemia. The normal treatment for this condition is a stem cell transplant (SCT) which was to be sourced as soon as possible given the risk of progression of her disease. She was initially treated with chemotherapy and her condition went into remission. Mrs Doig had an unusual HLA type which was highly sensitised with many HLA antibodies. This meant any transfusion or SCT needed to be carefully tested to ensure it was suitable for Mrs Doig. Initial attempts were made to identify an unrelated stem cell donor but unfortunately one could not be found. As a result Mrs Doig's 2 sons were tested for haploidentical donors. As the SCT was coming from a son it would always be only a 50% match. It was determined that one of her sons was a suitable donor. During the testing undertaken on her son no virtual crossmatch comparing the donors HLA antibody profile to Mrs Doig's HLA type was undertaken despite it being known that Mrs Doig had an unusual HLA type with many HLA antibodies. This was due to a failure to appreciate the significance of this testing for Mrs Doig, a communication failure between the hospital and the transfusion service, no additional sample being sent for Mrs Doig and no MDT being undertaken to discuss the treatment being proposed, thus losing the opportunity to discuss existing donor specific antibodies and the risk of SCT graft failure. Mrs Doig was admitted to hospital for pre transplant conditioning on 27/03/24 and received a SCT from on 04/04/24 to which she had an extreme reaction. By 25/04/24 the SCT had not engrafted and further checks were done which identified that there were specific antibodies present which explained the failure of the SCT. Mrs Doig remained in hospital and was treated for infection until she was well enough to be discharged home on 31/05/24. An umbilical cord donor was identified, and Mrs Doig was admitted to hospital on 13/06/24 for pre transplant conditioning before she received a double umbilical cord transplant on 29/06/24. Post transplant Mrs Doig had low grade fevers and raised inflammatory markers and was treated for bacteraemia. Mrs Doig deteriorated on 31/07/24 and was treated for atypical respiratory infection. She was admitted to ITU on 06/08/24 and it was confirmed that the SCT had grafted on 07/08/24. Whilst on ITU she was treated for chest sepsis and developing multi organ failure and had PV bleeding. She remained very unwell and had two cardiac arrests on 14th and 16th August. She sadly passed away later than day. Tests taken during the last days of her life confirmed that sadly her underlying condition had progressed to acute myeloid leukaemia which was untreatable.** Based on information from the Deceased's treating clinicians the medical cause of death was determined to be: **1a Multiple organ failure** **1b Sepsis due to immunosuppression from stem cell transplants** **1c myelodysplasia progressing to acute myeloid leukaemia** **1d** **II failed first stem cell transplant and subsequent second stem cell transplant**

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. – 1. The inquest heard evidence that the haematology department at the time of Mrs Doig's stem cell transplant was understaffed and working beyond its capacity quite often leaving the team with very little time for comprehensive reviews. [redacted], consultant haematologist at University Hospitals NHS Foundation Trust confirmed at the inquest that the position remained the same today. This raises a concern that further deaths will occur and action is required.
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 11 July 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 of Tina Doig NHSBT I have also sent it to the Medical Examiner, NHS England, CQC, 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. She may send a copy of this report to any person who she 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	**16 May 2025** Signature:  **Louise Hunt** **Senior Coroner for Birmingham and Solihull**