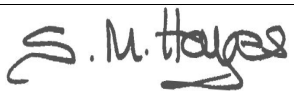
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. NHS Improvement - NHS Cervical Screening Programme (NHS CSP) 2. National Institute for Health and Care Excellence
1	**CORONER** I am Sonia Hayes, Area Coroner, for the coroner area of Essex
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 24 September 2024 , I commenced an investigation into the death of QUY THIS PHAM, AGE 29 . The investigation concluded at the end of the inquest on 5 August 2025. The conclusion of the inquest was 1a Metastatic Pulmonary Hypertension 1b Cervical Carcinoma. Narrative: Natural Causes: Quy Thi Pham died of an extremely rare but recognised and rapid progression of an early-stage cervical cancer resulting in tumour cells impacted within the small pulmonary vasculature that caused her death.
4	**CIRCUMSTANCES OF THE DEATH** Quy Thi Pham died on 3 September 2024 at Basildon Hospital of Metastatic Pulmonary Hypertension due to Cervical Carcinoma approximately 5 months post-partum. Ms Pham had been called for routine cervical screening during her pregnancy on 2 occasions and was informed according to guidance that she needed to wait until she was 12-weeks post-partum, and this was repeated on 6 June 2024 when Ms Pham again attended. The GP surgery made an appointment for 5 July by text that was not acknowledged. A rescheduled appointment for 25 July 2024 was cancelled by the surgery due to staff shortages and was not rebooked. Ms Pham attended her GP surgery on 2 September 2024 with a several days history of pleuritic chest pain and shortness of breath and Ms Pham was sent to Basildon Hospital where she was treated for suspected pulmonary embolism. Ms Pham had low blood pressure with tachycardia and tests confirmed signs of right heart strain with

	suspicion of pulmonary embolism with sub-optimal scan due to breathing difficulties. Ms Pham continued to deteriorate and was admitted to intensive care on 3 September where she went into cardiac arrest that did not respond to treatment including thrombolysis. Ms Pham was found on post-mortem to have a heavy load of metastatic tumour cells that had impacted in the pulmonary vasculature that had spread from an early-stage cervical primary tumour that caused right heart strain. This led to cardiac arrest that was irreversible. Natural Causes: Quy Thi Pham died of an extremely rare but recognised and rapid progression of an early-stage cervical cancer resulting in tumour cells impacted within the small pulmonary vasculature that caused her death.
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) Ms Pham had received 2 alerts for a routine smear test when pregnant and attended the GP surgery. Ms Pham was informed that she should wait until she was post-partum according to the National Cervical Screening Guidance. (2) Ms Pham attended the GP surgery at approximately 9 weeks post-partum and was informed that she must wait until she was at least 12 weeks post-partum to have her smear. This appointment was then cancelled due to staff shortages. (3) The Trust hospital Consultant explained that the most important factor to diagnose a patient is having a smear test and that it was not prohibited to have a smear test at 9-weeks post-partum, especially if a patient had not had a previous smear test, as in the case of Ms Pham who had an early-stage cervical cancer with no infiltration into surrounding organs or structures. (4) The Trust hospital Consultant had raised concerns about the National Cervical Screening Guidance in the past and that may mean that a cohort of women may be excluded: i. The national guidance to identify post-cotidal bleeding as a symptom of concern for cervical cancer may not be helpful as not all post-partum women have resumed coitus ii. Post-partum lochia can persist or be misinterpreted, meaning that bleeding may not be understood as abnormal

	iii. Women may not have a regular menstrual cycle, and bleeding may not be easy to identify as intermenstrual in accordance with the national guidance to give rise to a cause for concern iv. Rare complications of early-stage cervical cancer may not always manifest with symptoms of bleeding v. Not all women residing in the UK have had the HPV vaccine Those providing cervical screening services may be strictly applying the national guidelines and, with the proposed changes in National Screening this may increase the risk for women identified above.
6	**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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 6 October 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: • Family • Mid & South Essex NHS Trust • GP I have also sent it to: Care Quality Commission Royal College of General Practitioners Pathologist who may find it useful or of interest. 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 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	

	 **11 August 2025** **HM Area Coroner for Essex Sonia Hayes**