REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1 [redacted] Chief Executive Officer, West Suffolk Hospital** **2 [redacted] Chief Executive Officer, Suffolk and North East Essex Integrated Care Board**
1	**CORONER** I am Darren STEWART OBE, HM Area Coroner for the coroner area of Suffolk
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 03 February 2025 I commenced an investigation into the death of **Brigitte Dominique FAVRE** aged **69.** The investigation concluded at the end of the inquest on 06 November 2025. The conclusion of the inquest was: **Narrative Conclusion - In early 2024 Brigitte Dominique FAVRE was diagnosed with small cell leukaemia, an aggressive form of leukaemia with a high mortality rate. Ms. FAVRE received treatment including chemotherapy which finished in August of 2024. Early indications were that the treatment had been effective in dealing with the cancer.** **Sadly, in December 2024, Ms. FAVRE suffered a relapse of the cancer and she was admitted to West Suffolk Hospital where she resumed chemotherapy treatment in the hope that the cancer would respond in a similar manner to what had occurred earlier in that year.** **At the time the first round of chemotherapy was commenced, it was noted that Ms. FAVRE's sodium levels were low and that this was likely to require further treatment and monitoring. She was admitted to hospital on the 27th December 2024 with significant hyponatremia, which was treated. During this admission she was also diagnosed as suffering from a urinary tract infection which, in addition to managing her sodium levels, impacted on the timing of her second round of chemotherapy which did not then occur until 22nd January 2025. As part of this procedure, there was a degree of extravasation leakage of the chemotherapy drug into the tissue surrounding the site of the injection.** **Ms. FARVE was discharged on Saturday the 25th January 2025 and returned home. As the discharge occurred on a weekend, oncology input to inform the discharge was not possible, although discharge criteria had previously been set by the treating oncology consultant. On returning home Ms. FAVRE was unable to mobilise effectively and her general condition deteriorated acutely within a short period of time. She was re-admitted to West Suffolk Hospital on 26th January 2025, less than 24 hours following her discharge the day before. It has not been**

	possible to determine whether the criteria set out by the oncology department for Ms. FAVRE's weekend or out of hours discharge were met at the time of her discharge on 25th January 2025. **Following readmission Ms. FAVRE was diagnosed as suffering from both hospital acquired pneumonia and a further urinary tract infection and she was commenced on broad spectrum antibiotics. Poor record management meant that emergency department staff did not identify the fact that Ms. FAVRE had recently received chemotherapy treatment. As a consequence, post chemotherapy support medications were not administered. This, however did not make a contribution to her death.** **Ms. FAVRE's condition subsequently deteriorated further and she developed sepsis. Brigitte Dominique FAVRE died on the 30th January 2025.** **The effect of the chemotherapy she had been receiving was to reduce her white blood cell count leading to a decreased ability for her immune system to effectively fight off infection and increasing her risk to catastrophic conditions such as sepsis. This is a recognised complication of chemotherapy treatment.** **It has not been possible to establish whether the failed discharge made a contribution to Ms. FAVRE's death.** **Bridget Dominique Farve died due to a recognised complication following the receipt of necessary medical treatment for small cell cancer.** The medical cause of death was confirmed as: **1a Neutropenic Sepsis** **1b Chemotherapy** **1c** **1d** **2 Small Cell Lung Cancer**
4	**CIRCUMSTANCES OF THE DEATH** **Narrative Conclusion see above.**
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 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: **The Inquest heard evidence that at the time of Ms. FAVRE's discharge on the 25th January 2025, no oncology input was available on weekends or out of hours to inform discharge decision making. Criteria had been set by the treating Consultant Oncologist, however the evidence received at Inquest suggested that this was neither known nor followed in relation to Ms. FAVRE's discharge. I found as a fact that the discharge of Ms FAVRE on the 25th January 2025 was a failed discharge although it was not possible to establish whether the failed discharge made a contribution to Ms. FAVRE's death.** **Upon readmission to West Suffolk Hospital on 26th January 2025, poor records management meant that emergency department staff at West Suffolk Hospital did not identify that Ms. FAVRE had recently recieved chemotherapy treatment and as a result chemotherapy support medication**

	was not administered. Although this made no contribution to Ms. FAVRE's death, I am concerned that in the case of other patients such a failure may have a different adverse outcome. **I therefore have two concerns:** **1. The provision of on-call oncology support over weekends and out of hours to inform discharge planning and assist in reducing the incidence of failed discharge amongst cancer patients.** **2. The record management in the emergency department, including the ability of emergency department staff to interrogate West Suffolk Hospital records in a timely and consistent manner in order to inform clinical decision making concerning patients who have either recently been discharged or are receiving ongoing outpatient care.**
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 January 27, 2026. 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 Brigitte Dominique FAVRE** 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 other 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. 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.
9	**Dated: 02/12/2025** [redacted] **Darren STEWART OBE** **HM Area Coroner for Suffolk**


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