

	<p><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO: SHEFFIELD TEACHING HOSPITAL NHS FOUNDATION TRUST</b></p>
1	<p><b>CORONER</b></p> <p>I am Carl J Fitch, His Majesty's Assistant Coroner for the coroner area of South Yorkshire West.</p>
2	<p><b>CORONER'S LEGAL POWERS</b></p> <p>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.</p>
3	<p><b>INVESTIGATION and INQUEST</b></p> <p>On 23 June 2025 I commenced an investigation into the death of Graham Ian OXLEY. The investigation concluded at the end of the inquest on 19th March 2026.</p> <p>The conclusion of the inquest was -</p> <p>Graham Ian Oxley died on 22nd February 2025 at the Northern General Hospital, Sheffield after suffering serious side effects from pembrolizumab immunotherapy given following kidney cancer surgery. The treatment caused inflammation affecting his heart, muscles and nerves, which led to worsening problems with his breathing and heart. He was treated in hospital, but his condition continued to decline and life support treatment was stopped.</p> <p>The cause of death was established as:</p> <p>1a. Myositis, myocarditis and myasthenia gravis</p> <p>1b. Complication of pembrolizumab immunotherapy</p> <p>II. Renal cancer</p>
4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>Mr Graham Ian Oxley was diagnosed with renal cell carcinoma and underwent radical nephrectomy in October 2024. His Post-operative recovery included wound infection and persistent numbness around the surgical site. Follow-up imaging showed no metastatic disease and he was offered adjuvant pembrolizumab immunotherapy to reduce the risk of cancer recurrence. Pembrolizumab was administered on 9 January 2025, and within days, Mr Oxley developed symptoms including diarrhoea, fatigue, breathlessness, weakness and later neuromuscular impairment. He made repeated attempts to obtain advice via oncology emergency contact numbers, without success. He attended emergency care but was left without diagnosis.</p>

	<p>On 28 January 2025 he was admitted to Weston Park Hospital, appearing jaundiced with neuromuscular weakness. He rapidly deteriorated requiring intensive care. He was diagnosed with immunotherapy-related toxicity.</p> <p>He received escalating aggressive immunosuppressive treatment including steroids, IVIG and abatacept. Despite treatment, his condition progressed to multi-organ failure. Following discussion with his wife and clinicians, life-sustaining treatment was withdrawn.</p>
5	<p><b><u>CORONER'S CONCERNS</u></b></p> <p>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.</p> <p>The investigation has identified that immunotherapy is being used more frequently and there are concerns about the reliable operation of systems intended to support early recognition, escalation and access to specialist care for patients experiencing serious immunotherapy toxicity.</p> <p>The <b>MATTERS OF CONCERN</b> are as follows. -</p> <p>[BRIEF SUMMARY OF MATTERS OF CONCERN]</p> <p>(1) Urgent oncology advice - The Trust describes access to urgent oncology advice through a queue-based triage system and accepts that delays may occur. The response does not demonstrate how time-critical immunotherapy toxicity is reliably prioritised or escalated when delays arise.</p> <p>(2) Immunotherapy alert card pathway - Patients are issued with an immunotherapy alert card intended to signal urgent risk. The Trust's response does not show that possession or presentation of an alert card triggers a distinct fast-track or priority pathway, instead linking it to the same triage arrangements.</p> <p>These matters create a risk of future deaths where patients experiencing immunotherapy toxicity may encounter delay in accessing specialist advice and where urgent risk signals do not result in priority assessment.</p>
6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion action should be taken to prevent future deaths and I believe you SHEFFIELD TEACHING HOSPITAL NHS FOUNDATION TRUST have the power to take such action.</p>
7	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 20th May 2026. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons SHEFFIELD TEACHING HOSPITAL NHS FOUNDATION TRUST and [REDACTED], the wife of the deceased.</p>

	<p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>19 March 2026</p> <p>Signature </p> <p>Carl J Fitch H.M Assistant Coroner for</p>