

**REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS
2013**

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's [PFD Publication Policy \(2026\)](#).

1.	CORONER I am Victoria DAVIES, Area Coroner, for the coroner area of Cheshire.
2.	DATE OF REPORT 24 June 2026
3.	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.
4.	THIS REPORT IS BEING SENT TO 1. NHS England You are under a duty to respond to this report within 56 days of the date of this report, namely by August 19, 2026. I, the coroner, may extend the period if an appropriate application is made.
5.	YOUR RESPONSE 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary .
6.	SUMMARY OF CORONER'S CONCERN I am concerned that by following the NHS Pathways tool, advice was given to Mrs Bastedo which led to a delay in her attending hospital which may have proved critical.

7.	ACTION SHOULD BE TAKEN In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
8.	INVESTIGATION AND INQUEST On 18 February 2026 I commenced an investigation into the death of Sheila Bastedo aged 67 Years. The investigation concluded at the end of the inquest on 23 June 2026. The conclusion of the inquest was that Mrs Bastedo died from a recognised complication of necessary chemotherapy.
9.	CIRCUMSTANCES OF DEATH Sheila Bastedo had recently completed a cycle of chemotherapy for Langerhan's histiocytosis. A blood test on 9 February 2026 identified a neutrophil count of 0. As advised, on 12 February, when she began to feel unwell, Sheila and her husband contacted the Clatterbridge Cancer Centre for advice at around 8.45 and were told to call an ambulance and go immediately to A&E. This is accordance with NICE guidance on management of neutropenic sepsis. On calling the ambulance service, the advice given was to speak to a GP within an hour. The GP appointment was made for 15.20. By the time of the appointment, Sheila was very unwell and was advised to go straight to hospital. She attended the Countess of Chester Hospital and treatment was commenced for neutropenic sepsis. Despite full resuscitation measures, Sheila did not improve and her death was confirmed at 04.08 on 13 February 2026. I found that there were missed opportunities to get Sheila to hospital sooner, but these did not cause or contribute to her death. The missed opportunities were: - Clatterbridge to enquire as to whether she could make her own way to hospital rather than call an ambulance. - Advice given by the ambulance service to speak to a GP instead of going to hospital.
10.	CORONER'S CONCERNS During the course of the inquest I heard evidence 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: Advice given by the ambulance service, following NHS Pathways, is inconsistent with the NICE guidelines on management of neutropenic sepsis. Evidence was heard from two medical consultants that, in a patient who has recently undergone chemotherapy, if they report a high temperature, this gives rise to a concern of neutropenic sepsis and they require urgent assessment in hospital. NICE guidance says to suspect neutropenic sepsis in patients

	having anticancer treatment who become unwell. Refer them immediately for assessment in secondary or tertiary care. The advice given, following the NHS Pathways tool, was to seek advice from primary care. The NHS Pathways does not appear to take into account the recent chemotherapy and the risk that this poses. The evidence I heard from the clinical delivery manager was that thousands of people have cancer, it's a chronic condition and not acute, but this does not take into account that recent chemotherapy plus a temperature makes it acute. The evidence was that this is not a question in the Pathway and is therefore not a factor which is considered. As well as being at odds with the NICE guidance, the advice to contact a GP within an hour does not take into account the availability of a GP appointment, as the call handler does not have access to the booking system. There was no advice given about what to do if a GP could not be contacted within an hour, for example to go to hospital. It adds an extra step, and therefore delay, in what can be a time critical situation. The Pathways tool does not support giving advice for a patient to attend hospital themselves, if they are able.
11.	COPIES AND PUBLICATION OF THIS REPORT I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: <i>[please do not use individual's names, but instead roles/titles]</i> • [REDACTED], husband of the deceased • The Clatterbridge Cancer Centre • North West Ambulance Service NHS FT • The Countess of Chester Hospital NHS FT I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
12.	SIGNATURE



Victoria DAVIES
Area Coroner for
Cheshire