M. E. Voisin
Her Majesty's Senior Coroner
Area of Avon

30th January 2020 REF: 13847

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Secretary of State for Health** 2. **Royal College of Obstetricians and Gynaecologists**
1	**CORONER** I am M E Voisin Senior Coroner for **Area of Avon**
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 17/04/2019 I commenced an investigation into the death of Julie Sandra O'Connor. The investigation concluded at the end of the inquest 30th January 2020. The conclusion of the inquest was natural causes contributed to by neglect. Her medical cause of death was recorded as: 1a) metastatic squamous cell carcinoma of the cervix
4	**CIRCUMSTANCES OF THE DEATH** The brief circumstances were ... Julie O'Connor had a smear test in September 2014 which was reported as normal when it was not; she was examined by gynaecologists who did not diagnose her condition in August and November 2016. It was not until she was seen in March 2017 that she was appropriately diagnosed and treated for cervical cancer. Unfortunately despite treatment at that time her condition deteriorated, she developed metastatic disease due to the delayed diagnosis and she died on 4th February 2019 at St Peter's Hospice from metastatic squamous cell carcinoma of the cervix.
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.

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The **MATTERS OF CONCERN** are as follows. –

In this case as well as the fact that the smear test was incorrectly reported there were also 2 occasions when there was a failure to recognise a clinically obvious cancer of the cervix or a failure to recognise a need for further assessment in August and November 2016. In addition the evidence of the experts was that the abnormal appearance of the cervix should also have been diagnosed in February 2017.

The North Bristol NHS Trust have developed a guide for "the management of abnormal cervix, ectropian, and post coital bleeding"* and it is the view of the trust that if this guide had been in place at the time that Julie's medical condition would have been picked up earlier.

*I attach a copy of the guide produced by the Trust.

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 27th March 2020. 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 Julie O'Connor, North Bristol NHS Trust. Spire Bristol and [redacted] 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. 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.
9	30/01/2020 Signature_____ M E Voisin Senior Coroner **Area of Avon**

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