REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (2)

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

| | REGULATION 28 REPORT TO PREVENT FUTURE DEATHS |
|---|--|
| | THIS REPORT IS BEING SENT TO: |
| | Basildon and Thurrock University Hospitals NHS Foundation Trust |
| 1 | CORONER |
| | I am Caroline Beasley-Murray, senior 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 |
| | On 25 July 2017 I commenced an investigation into the death of David John Lindsey. |
| 4 | CIRCUMSTANCES OF THE DEATH |
| | David John Lindsey was born on 1 December 1944 and he died at his home address on 25 July 2017. The cause of death provided by the pathologist after a post mortem examination is 1a) small bowel cancer. Mr Lindsey's medical history included diverticulosis, gastritis and a hernia repair. It would appear that Mr Lindsey had undergone investigations at Basildon Hospital during a period of over a year. No diagnosis was made nor treatment given. The tumour was found to be 7cms by 11cms in size |
| 5 | CORONER'S CONCERNS |
| | During the course of the investigation my inquiries 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. – |
| | [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) The family contend that the trust has failed to follow NICE guidelines in respect of cancer screening, referrals, diagnosis and treatment (2) They further contend that the trust has failed to follow its own policies and guidelines in this regard. |
| 6 | ACTION SHOULD BE TAKEN |
| | In my opinion urgent action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action. |
| | |
| | Cont |

YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by 9th November 2017. 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. COPIES and PUBLICATION I have sent a copy of my report to the Chief Coroner and to the following Interested Persons who may find it useful or of interest. Family of Mr Lindsey 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. 14 September 2017 9 **Caroline Beasley-Murray**