REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** The Chief Executive, Nottingham University Hospitals NHS Trust (NUH)
1	**CORONER** I am Miss Sarah Wood, Assistant Coroner, for the coroner area of Nottinghamshire.
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 the 23rd of November 2022, I commenced an investigation into the death of Michael David Daft. The investigation concluded at the end of the inquest on the 22nd of November 2023. The conclusion of the inquest was natural causes.
4	**CIRCUMSTANCES OF THE DEATH** Michael was diagnosed with rectal cancer on the 30th of July 2021. A left renal mass was also identified, and further tests had to be undertaken to identify its cause. There were delays in establishing the renal diagnosis and the colorectal surgery was postponed until the outcome of that was known. A diagnosis of renal cell carcinoma was confirmed on the 5th of November 2021 and the necessary surgery for both conditions was planned for the 3rd of December 2021 but was cancelled due to no HDU bed. Further scans identified a progression of the rectal cancer and Michael was referred to Oncology for treatment, which commenced in January 2022. Michael's cancer did not respond to treatment, and he was admitted to hospital on the 8th of November. He deteriorated rapidly and died on the 10th of November 2022, at City Hospital, Nottingham, from a perforated bowel, secondary to tumour progression. Detailed findings as to how he came by his death are described within a written Determination dated 22nd of November 2023, appended to this report.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed a matter 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 **MATTER OF CONCERN** is as follows –

	• There is little evidence to date of effective communication between Multi-Disciplinary Teams (MDT) from different specialisms when a patient is on more than one treatment pathway. In my opinion, action should be taken to prevent future deaths and I believe you have the power to take such action.
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 the 19th of January 2024. 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: 1. [redacted], Michael's wife. 2. The Nottingham University Hospital Trust (NUH). 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 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. 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	**24th Of November 2023 Miss Sarah Wood**