Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1. Department of Health and Social Care** **2. Cambridgeshire & Peterborough Integrated Care System** **3. NHS England**
1	**CORONER** I am Caroline Jones, Assistant Coroner for the coroner area of Cambridgeshire & Peterborough.
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 29 July 2022, I commenced an investigation into the death of Gregor Patrick Edward Lynn aged 24 years. The investigation concluded at the end of the inquest on 30 August 2023. The conclusion of the inquest was that: • Gregor died of natural causes due to a disseminated metastatic melanoma • He had developed a lesion on the back of his neck in March 2019 which was excised privately but the excised material was not sent for histological analysis, likely due to the additional cost associated with having to have the samples analysed privately • By the time the lesion recurred in May 2020 and was examined under the urgent care dermatology pathway, it was found to be a melanoma which had metastasised and was beyond effective treatment.
4	**CIRCUMSTANCES OF THE DEATH** In March 2019, the consequence of Gregor not meeting the referral criteria for NHS treatment upon initial presentation with a nuisance lesion to the back of his neck was that he had to self-refer for private treatment at a reported cost of c.£140. He was advised that the additional cost of histological analysis of the excised samples would be c.£65 and so decided not to have the samples sent for analysis. When the lesion continued to trouble him in May 2020, he returned to his GP who referred him to dermatology, where a further excision was performed and analysed and was found to be melanoma. An ultrasound scan showed that the melanoma had metastisised to his lymph nodes, chest wall and lungs. Despite immunotherapy and targeted oral therapy, the melanoma continued to metastasise and in June 2022, scans showed that it had spread to Gregor's brain such that his condition was terminal. He was placed onto a palliative care pathway and following an admission to Addenbrooke's hospital on 6 July 2022, he died on 8 July 2022.
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	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 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: • I was not able to conclude that, had the sample been sent for analysis in March 2019, any sign of melanoma would have been detected. Nevertheless, it is of concern that the barrier to undergoing a complete procedure, including histological analysis, appears to be one of cost. Anecdotal evidence received at inquest from treating clinicians was that the further costs associated with histological or other review, which on the NHS would be routinely included within the procedure at no charge to the patient, was a common disincentive to patients who would regularly opt not to have the further tests carried out. • While it is acknowledged that there have to be criteria for routine and non-emergency procedures to be conducted on the NHS, my concern relates to the disparity in what is included within the treatment when undertaken privately (where histological analysis is a separate and additional cost) and what is routinely included as part of NHS treatment • It therefore seems to me that there is a risk of future deaths if patients not meeting the NHS referral criteria, who have to pay for procedures to be carried out privately, opt on cost grounds not to have the histological analysis which would otherwise be provided on the NHS at no charge, as it is well-established fact that earlier detection and treatment is crucial in minimising the risks of developing metastatic cancers including melanoma.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) 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 February 14, 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. Family of Gregor Lynn 2. [redacted] GP as well as the other recipients identified at the top of the report. 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	**Dated: 20/12/2023**  **Caroline JONES** **Assistant Coroner for** **Cambridgeshire and Peterborough**