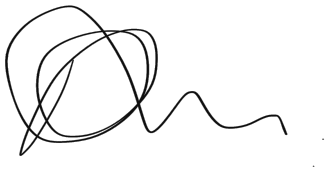
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Chief Executive Officer of Mid and South Essex NHS Foundation Trust, [redacted]
1	**CORONER** I am Rebecca Mundy, HM Assistant Coroner, for the coroner area of Essex.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 8 February 2024 I commenced an investigation into the death of William Charles Hare (Bill), 71. The investigation concluded at the end of the inquest on 3 December 2024. The conclusion of the inquest was a narrative conclusion outlining that Mr Hare had died from metastatic urothelial cancer, contributed to by neglect, namely delays to diagnosis and treatment resulting in the cancer spreading to such an extent any treatment that could have been given, became futile.
4	**CIRCUMSTANCES OF THE DEATH** Bill presented to Basildon Hospital in November 2022 with abdominal and left loin pain. Following CT scans and discussion at a Multi-Disciplinary Team (MDT) meeting, it was suspected that Bill had cancer in the middle-left ureter. The MDT determined that an MRI and CT chest be carried out as well as a consultation with Bill. The MRI showed no obvious urothelial lesions and so the advice was that if concerns remained, a ureteroscopy was recommended. Following a consultation with Bill on 4 January 2023 a ureteroscopy was requested. This was undertaken on 16 February. The results of the biopsy were available on 7 March but were inconclusive. The MDT considered next steps on 21 March and advised that imaging and biopsy be repeated with a view to a nephroureterectomy being undertaken. A telephone consultation took place with Bill on 27 March and he was referred to a Consultant Urological Surgeon. Bill was not seen until 23 May. The Consultant adopted the plan set by the MDT, although he felt that Bill would ultimately require surgical intervention. A CT scan was repeated on 5 June but it wasn't until 29 August that Bill's case and ongoing plan was next reviewed by the MDT. No one giving evidence could explain that delay. It was decided that given the delays Bill should proceed to have surgery; either a segmental ureterectomy or a nephroureterectomy.

	Bill attended a pre-assessment clinic on 4 September, but due to an elevated HBA1c of 104 he was deemed unfit for surgery and instructions were given that he was to be seen in the Diabetic Clinic and re-referred when his HBA1c was below 70. In the meantime, Bill presented to Basildon hospital again on 3 October with hyponatremia secondary to diarrhoea and hyperglycaemia secondary to poorly controlled diabetes. His left kidney showed very poor function. There was no evidence of bone metastasis. He was discharged on 25 October. However, he presented again on 17 November with low sodium and sepsis with a left nephrostomy tube. Further scans and investigations were undertaken but no positive action was taken in progressing Bill's diagnosis or treatment plan. By the time an MRI was undertaken on 20 December, there was evidence of disease progression. Bill was due to be moved to Southend Hospital for specialist treatment by the renal team during this admission, however, due to a combination of a lack of beds, ward closures, junior doctor strikes, a full ITU and issues with transport, he remained in Basildon until 3 January 2024. By this time, his cancer had metastasised to his bladder and psoas muscle. A further CT scan, the results of which only became available on 15 January, revealed that it has also spread to his lungs. Treatment had become futile. Bill was placed on an end-of-life care plan and moved to a hospice where he passed away on 23 January.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence 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. There was an overall delay in reaching any diagnosis in Bill's case and, therefore, any treatment plan being implemented. ii. There was a delay in the first biopsy being taken which ultimately took place well outside the national guideline of 31 days. iii. There was a delay from the MDT referring the case to the Consultant, to an appointment taking place in May 2023. iv. There was an additional delay between the further CT scan ordered by the Consultant, which took place on 5 June, and the MDT which considered the results and treatment plan on 29 August, notwithstanding the fact that the MDT meet weekly and Bill's case

	could have been considered at any of those meetings. v. A further delay occurred from 4 September, as Bill had been assessed as unfit for surgery due to his HBA1c reading. Whilst this is unlikely to have been related to the cancer, there was likely to have been an opportunity, had his case been progressed earlier, at which his HBA1c was at an acceptable level for the procedure to be carried out. vi. In his last admission to Basildon Hospital between November 2023 and January 2024 there were delays in progressing his treatment due to the disjointed nature of the inter-relationship between Basildon and Southend Hospitals as well as delays in transporting him to Southend Hospital which included failures to organise transport and properly coordinate his transfer. vii. A final delay occurred in the results of a CT scan, the results of which were not available until 15 January. By this time, the cancer had spread throughout Bill's body and became untreatable. viii. Among the delays, and potentially contributing to them, were a series of systemic and procedural errors largely related to processes controlled by isolated computer systems or people who are not medically trained. One example is the default of a referral or request to "routine". ix. The lack of a specialist renal consultant at the MDT and lack of effective interaction between the people and systems at Southend and Basildon Hospitals prevented quick and effective decision making and, therefore, progress of Bill's diagnosis and treatment.
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 17 February 2025. 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 Bill's family. I have also sent it to The Care Quality Commission, who may find it useful or of interest.

	Further, I am 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	**23 December 2024**  **Rebecca MUNDY, HM Assistant Coroner**