REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1 Managing Partner, Alexandra & Crestview Surgeries, Alexandra Road, Lowestoft** **2 [redacted], Alexandra & Crestview Surgeries, Alexandra Road, Lowestoft**
1	**CORONER** I am Darren STEWART OBE, HM Area Coroner for the coroner area of Suffolk
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 09 October 2023 I commenced an investigation into the death of **Terence COLBY** aged **82.** The investigation concluded at the end of the inquest on 24 September 2024. The conclusion of the inquest was: **Natural causes** The medical cause of death was confirmed as: **1a Peripheral Vascular Disease**
4	**CIRCUMSTANCES OF THE DEATH** **Terence COLBY was admitted to hospital with ulceration and purplish discoloration on the left fourth toe and swollen inflamed ipsilateral foot on the 19th August 2023. Mr Colby had been complaining of swelling and throbbing pain to his left toe since June 2023 which had been treated as gout. He had been assessed by a GP on the 17th August 2023.** **Mr. COLBY's family took him to A&E on the 18th August 2024 following which he was admitted on the 19th August 2024. Following assessment, Mr. COLBY was diagnosed with critical limb ischaemia secondary to peripheral vascular disease with an acute on chronic occlusion of his left leg and foot. Attempts at re-perfusion were made with no success. He had a below knee amputation to his left lower limb on 29th August 2023 and was stable post-operation. However, he developed hospital acquired pneumonia on 6th September 2023 and then suffered from a pulmonary embolism the following day (7th September 2023). He continued to deteriorate until it became clear to treating clinicians that he was unlikely to improve.** **Following discussions with his family, Mr. Colby was transferred to a hospice for**

	end-of-life care. He was admitted to a hospice on 26th September 2023 where he died on 27th September 2023.
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 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: **During the Course of the Inquest evidence was received in the form of a Report from an Expert in General Practice, commissioned by the Court and which considered the care and treatment provided to Mr. COLBY by his GP Practice (Alexandra & Crestview Surgeries, Lowestoft). The Report highlighted substantially sub-standard practice provided to Mr. COLBY on the 17th August 2023 by Alexandra & Crestview Surgeries. This was as follows:** **On 17th August 2023, despite the presence of a wound on the foot and the report of leg pain, there was a failure by the examining GP to undertake a simple vascular examination of Mr. COLBY's limb.** **The Expert Report highlighted that this was despite the fact that "As per the NICE guidance already quoted, peripheral arterial disease needed to be considered here and this was a patient who had attended face to face. In my view this was substantially sub-standard practice and a failure to provide basic medical care (failure to examine) and was against national guidelines."** **Although the Inquest did not conclude that the failure identified above was causative of Mr. COLBY's death, I am concerned that should such practice continue, without remedial action, then there is a risk of future death in other patients.**
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 August 13, 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 the following Interested Persons **The family of Terence COLBY** **Norfolk and Norwich University Hospitals NHS Foundation Trust** I have also sent it to

	Care Quality Commission **The Royal College of General Practitioners** who may find it useful or of interest. 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 other 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.
9	**Dated: 18/06/2025**  **Darren STEWART OBE** **HM Area Coroner for** **Suffolk**