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:** **NHS ENGLAND**
1	**CORONER** I am Samantha GOWARD, Senior Coroner for the coroner area of Norfolk
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 30 September 2024 I commenced an investigation into the death of Michael Leonard MOORE aged 83. The investigation concluded at the end of the inquest on 04 September 2025. **The medical cause of death was:** 1a) Recurrent Metastatic High Grade Urothelial Carcinoma 1b) 1c) 1d) 2) Left Subacute Frontal Infarct, Ischaemic Heart Disease **The conclusion of the inquest was:** Died due to underlying natural causes, the diagnosis and treatment of which was delayed due to lengthy waiting lists.
4	**CIRCUMSTANCES OF THE DEATH** 1. In summary, Mr Moore was being managed under the hospital's Urology team after a previous diagnosis of high risk non-muscle invasive bladder cancer for which he was having surveillance cystoscopies (bladder checks) since 2021. He had also had radiotherapy for prostate cancer in 2012. 2. At a check up in July 2023, an abnormal area was noted, and a biopsy was requested. While he was still awaiting the biopsy, some 9 months later, he was admitted as an emergency in April 2024. On examination he was found to have a mass causing compression. A defunctioning colostomy was performed to bypass the obstruction on 15 April 2024 and a biopsy taken which showed disease in keeping with spread from a high grade urothelial carcinoma (bladder cancer) which was said to be advanced and not curable. He was seen on 2 July 2024 by an Oncologist who felt that due to the advanced cancer and his frailty, active treatment was not in his best interests & Mr Moore was placed under the care of the palliative team and died at home on 17 September 2024. 3. The evidence heard was that there was a delay in the biopsy being performed after the check up in July 2023 due to lengthy waiting lists at the Trust. I was advised that Mr Moore should have had his biopsy within 28 days – so by late August 2023.

	It was not done until April 2024, and then only as he was admitted as an emergency. This was therefore approximately an 8 month delay (and based on the fact he was still on the waiting list, would have been longer if not for the emergency admission). 4. I heard evidence that he suffered a cerebral infarct in June 2024 while awaiting Oncology review. It was said in July 2024 when he was seen by an Oncologist that the only treatment option for him was palliative chemo, but he was not fit enough to undergo that treatment. 5. If he had undergone a biopsy in August 2023, on the basis of the evidence heard I found that this would have identified the reoccurrence of the cancer at that time. On the balance of probabilities the cancer would have been at an earlier stage and there would have been more treatment options available. It was not possible to say on balance of probabilities, based on available evidence, that any treatment would have been curative given the nature of the cancer and his frailty, but it is a possibility and there was a missed opportunity to commence earlier treatment.
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 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: The evidence of the Hospital Trust was that work had been ongoing in recent years to reduce delays, but that while there had been some initial improvement, there had been a further decline which I was told is in part due to an increase in referrals due to high profile celebrities announcing their cancer diagnoses and rightly encouraging people to come forward with any symptoms of concern. Therefore, despite local measures to improve performance, this has been significantly affected by a rise in cancer referrals. I was advised that this surge has been widely reported across the NHS and I was advised that NHS England has acknowledged persistent capacity constraints across many providers. The concern therefore is that the NHS does not have the ability to deal with the significant number of cancer referrals received and this is causing significant delays in waiting times which impacts on those awaiting a diagnosis, undergoing surveillance and delays in diagnosing a recurrence and those awaiting treatment.
	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 November 06, 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: Mr Moore's family Norfolk and Norwich University Hospital

	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: 11/09/2025** [redacted] **Samantha GOWARD** **Senior Coroner for Norfolk** County Hall Martineau Lane Norwich NR1 2DH