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 [redacted], Interim Chief Executive, Care Quality Commission** **2. [redacted]r, Chief Executive, Royal College of Surgeons**
1	**CORONER** I am Darren STEWART OBE, HM Assistant Coroner for Surrey for the coroner area of Surrey
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 10 September 2021 I commenced an investigation into the death of Gary STARBUCK aged 81. The investigation concluded at the end of the inquest on 12 December 2025. The conclusion of the inquest was: Narrative Conclusion - Gary STARBUCK was a much loved and desperately missed member of his Family. He was a man who had a great zest for life, a keen and energetic sportsman, something he managed to sustain well into his 70's. Mr. Starbuck was known for his warm, welcoming hospitality, an optimistic man with a fantastic dry sense of humour. He was one of those people who would make a person feel uplifted by having been in his company. His Family recalls him as someone who could be relied upon to radiate calmness in a crisis and was always there to support his children, his broader Family and friends. He was loyal, kind, generous and fair. A person who during his life had a significant, positive impact on the lives of those around him. During his life, Mr Starbuck had spent time living in Australia where he had been exposed to the effects of the sun and this is likely to have resulted in damage to his skin which subsequently led to him contracting skin lesions in the form of basal and squamous cell carcinomas. Mr. Starbuck's previous medical history included a diagnosis of hypertension and hairy-cell leukaemia, the latter diagnosed in 2006 and for which he received treatment including chemotherapy. He had suffered a cerebrovascular accident in 2017. Due to his diagnosis of and treatment for hairy-cell leukaemia, Mr. Starbuck suffered from immunosuppression which impacted on his subsequent treatment and increased his risk of contracting further disease. As a consequence, Mr. Starbuck presented as a patient with complex considerations for his clinical care and management.

	Between 2011 and 2017 Mr. Starbuck underwent numerous procedures to excise skin lesions which were believed to be due to previous sun exposure. In January 2017 he underwent an excision on his right pinna (ear) for what was believed to have been a basal cell carcinoma. Subsequent pathology analysis determined that this was in fact a squamous cell carcinoma. The clinician performing this procedure assessed at the time that this tumour had been completely excised although close to acceptable margins. In January 2018 a tumour was identified again on the right pinna and which was excised. Further testing determined that the tumour was a squamous cell carcinoma which had not been successfully excised within clinical margins. Two subsequent attempts to excise this tumour in March and June 2018 were unsuccessful. The care and treatment for Mr. Starbuck in relation to this squamous cell carcinoma and ongoing treatment for other skin cancers was transferred to another clinician in June 2018. Mr. Starbuck underwent radiotherapy treatment which seemed to cure the tumour and he experienced a period of time where there appeared to be no recurrence of this tumour. During this time Mr. Starbuck continued to experience other skin lesions which were treated. In May 2020 it was assessed that the squamous cell carcinoma which had been treated in 2018 had recurred and metastasised to Mr. Starbuck's lungs. Further intensive treatment, including re-irradiation and immunotherapy were sadly unable to cure the cancer and it metastasised further to Mr. Starbuck's neck. Mr. Starbuck's care transitioned in July 2021 from curative to palliative care and he died at home on the 16th August 2021. A post-mortem examination of Mr. Starbuck's body established that his medical cause of death was due to Metastatic Cutaneous Squamous Cell Carcinoma. Gary STARBUCK died due to the metastases of a cutaneous squamous cell carcinoma, a naturally occurring condition. The medical cause of death was confirmed as: 1a Metastatic Cutaneous Squamous Cell Carcinoma
4	**CIRCUMSTANCES OF THE DEATH** Narrative Conclusion see Box 4
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 Inquest heard evidence that Mr. Starbuck's care and treatment for his skin cancers was initially provided privately. National guidance published by the National Institute for Health and Care Excellence (NICE) sets out that any patient with a high risk Squamous Cell Carcinoma (SCC) should be referred to a specialist skin MDT (SSMDT.) Specifically, this is something which should have occurred following excision of a SCC. This is mandated practice within the NHS and the overwhelming evidence before me was that this applied to clinicians practicing in NHS. The situation in relation to patients being treated privately was less clear; evidence

	from several witnesses ranged from the position that this guidance was as binding on clinicians treating patients privately as in NHS, to the guidance was just that 'guidance' to be applied by the clinician within the framework of care being provided privately. The latter was relevant in the context of how clinicians treating patients privately would access the SSMDT. The evidence received was that normally this was via the treating clinician taking the patient to the relevant NHS SSMDT or in less frequent occasions where the Hospital had a private SSMDT to deal with patients being treated privately. No mandatory policy exists beyond the NICE guidance. As a consequence, whilst the policy is mandated for patients in receipt of NHS Care and Treatment, it is not mandatory for patients being treated for the same conditions privately. There are many clinicians who import the NICE Guidelines into their private practice, along with NHS Trusts who accept referrals from clinicians treating patients privately into the SSMDT for consideration. However, as this is not mandated practice for either clinicians or convenors of SSMDT's, the consequence is that patients treated privately are at risk of receiving inferior care to those treated under the NHS, often within the same physical hospital setting. I am concerned that there is a lacuna in mandated care standards for patients treated privately by clinicians within the regulatory framework which gives rise to a risk of death.
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 June 3rd, 2026. 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 **Family of Gary Starbuck** **Royal Surrey NHS Foundation Trust** **Nuffield Health Guildford Hospital** **Mount Alvernia Hospital** [redacted]**, Consultant Oral and Maxillofacial Surgeon and Facial Plastic Surgeon** [redacted]**, Consultant Oral and Maxillofacial Surgeon** I have also sent it to **National Institute for Health and Care Excellence** **General Medical Council** 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: 08/04/2026** [redacted] **Darren STEWART OBE** **HM Assistant Coroner for Surrey for Surrey**