**Mr Andrew Walker**
HM Senior Coroner for North London
Barnet Coroner's Court
29 Wood Street
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EN5 4BE

[redacted]

**National Medical Director**
NHS England
Wellington House
133-155 Waterloo Road
London
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[redacted]

**31st August 2026**

Dear Mr Walker,

**Re: Regulation 28 Report to Prevent Future Deaths – Keith Richard Gandy who died on 29th October 2025.**

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 5th June 2026 concerning the death of Keith Richard Gandy on 29th October 2025. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Mr Gandy's family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Mr Gandy's care have been listened to and reflected upon.

Your Report raised the following concerns:

1. That there is no guidance for GPs highlighting that a previous cancer in a patient is a red flag, and a referral for a specialist opinion should be made without waiting for further tests.

2. The referral waiting times for specialist evaluation in these circumstances are between 6 to 12 months.

**A lack of guidance for GPs**

National Institute for Health and Care Excellence (NICE) guidance NG12 Suspected cancer: recognition and referral, advises that clinicians use judgement when symptoms present in people with higher baseline cancer risk. Whilst it does not specifically list previous cancer as a red flag, a history of cancer is widely recognised clinically as such a factor.

GPs should be aware of 1) the risks of cancer recurrence in people who have been diagnosed with cancer, 2) the carcinogenic risk of some cancer treatments, such as radiotherapy, which we anticipate they could and would draw on in the management of patients, even in the absence of specific guidance on this topic.

Based on information in the inquest bundle, it would seem that in this case, the GP did consider metastatic prostate cancer quite quickly and initiated investigation accordingly.

On treatment-related cancer risks, we would expect any risks of cancer treatment, such as the risk of radiation-induced subsequent cancers, to be outlined to the patient at the point of treatment consent and reflected in the consent form.

**Referral waiting times**
This is primarily a matter for the region and the commissioners and providers in the locality. However, we would note that in this instance, the patient was seen by the sarcoma Multi Disciplinary Team very soon after the imaging suggested the diagnosis of sarcoma. The interval between the raised alkaline phosphatase noted in primary care and his first admission was 3 weeks, and he went on to the sarcoma service rapidly thereafter.

**Regional response**
Central East Integrated Care Board (ICB) have advised that the practise has confirmed that Mr Gandy's care was reviewed through a formal Significant Event learning meeting as part of an internal practice learning session. The practice has confirmed that its review did not identify any specific patient safety issues requiring further action by the practice and that, overall, the care provided was considered to have followed appropriate clinical guidance.

The practice did however, identify additional local learning from the case including the following:

- The importance of being alert to possible 'red herrings' in clinical presentation, particularly where symptoms may initially appear consistent with musculoskeletal injury or another diagnosis.
- The need to carefully examine and reassess the precise anatomical location of pain to ensure that any imaging or further investigation covers the area of clinical concern.
- Where a patient is clinically unwell, consideration should be given to whether hospital admission may be appropriate or required to expedite investigations.

The practice has advised that learning from this case has been disseminated with the wider clinical team during the Significant Event learning meeting which was attended by the clinicians working that day.

The ICB have advised that they have been assured that the practice has reviewed the case through its Significant Event learning process, has considered whether any patient safety issues were identified and has shared the learning within the practice. The ICB will also consider the broader learning from this case, particularly around persistent or evolving pain symptoms, previous cancer history, clinical reassessment and escalation, can be shared though appropriate primary care quality and patient safety routes. NHS England will share a copy of our response to your Report with the ICB to support this.

I would also like to provide further assurances on the national NHS England work taking place around the Reports to Prevent Future Deaths. All reports received are

discussed by the Regulation 28 Working Group, comprising Regional Medical Directors, and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around events, such as the sad death of Mr Gandy, are shared across the NHS at both a national and regional level and helps us to pay close attention to any emerging trends that may require further review and action.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,

National Medical Director
NHS England