REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

1.	**CORONER** I am Andrew Walker, HM Senior Coroner for the coroner area of North London.
2.	DATE OF REPORT 5th June 2026
3.	**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.	**THIS REPORT IS BEING SENT TO** 1. NHS England 2. 3. You are under a duty to respond to this report within 56 days of the date of this report, namely by 31st **July 2026**. I, the coroner, may extend the period if an appropriate application is made.
4.	**YOUR RESPONSE** 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.

5.	**SUMMARY OF CORONER'S CONCERN** Previous cancer is a red flag and a referral should be made without waiting for further tests. Guidance to GPs where referral for specialist evaluation waiting times are between 6 months to 12 months.
6.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
7.	**INVESTIGATION AND INQUEST** On 30th October 2025, I commenced an investigation into the death of Keith Richard Gandy aged 65 years. The medical cause of death was 1a. Multiorgan Failure 1b. Radiation-induced osteosarcoma of the pelvis (operated on 13/10/2025) II. Prostate Cancer **How, when and where** Keith Richard GANDY died in the Royal National Orthopaedic Hospital (Stanmore, London) on the 29th October 2025. **Conclusion** Keith Richard GANDY died as a consequences of a delay in recognition of a radiation induced osteosarcoma**.**
8.	**CIRCUMSTANCES OF DEATH** Keith Richard Gandy died in hospital on the 29th October 2025 after a lengthy period of deterioration following first presentation to his surgery following a fall. Mr Gandy had previously had prostate cancer and the focus was on concerns that the cancer had returned or spread together with pain management. The reason that Mr Gandy was in so much pain was discovered when a doctor at the surgery suspected a pubic rami fracture and Mr Gandy was sent to a walk in X-ray centre on the 8th August 2025. Mr Gandy was found to have an osteosarcoma.

	Mr Gandy was taken to theatre on the 13th October 2025 but despite this failed to recover. This was an extremely rare radiation induced osteosarcoma which, even if caught earlier, is likely to have had a poor outcome.
9.	**CORONER'S CONCERNS** During the course of the inquest I heard evidence 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: There was no guidance to GPs that underlines that previous cancer is a red flag and a referral for a specialist opinion should be made without waiting for further tests. That referral waiting times for specialist evaluation in these circumstances are between 6 months to 12 months
10.	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: 1. NHS England 2. The Gandy family 3. The Royal National Orthopaedic Hospital 4. Bedfordshire Hospital NHS Trust 5. Putnoe Medical Centre I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
	SIGNATURE **HM Senior Coroner Mr Andrew Walker**