Royal Court of Jersey
Deputy Viscount

30 March 2026

Sent by email

Dear Deputy Binet

Inquest: Victor Tinley - Report to Prevent Future Deaths

I am writing to you in your capacity as Minister for Health in respect of an inquest that I presided over on 19 March 2026, in relation to the death of Victor Charles Francis Tinley, who died from high grade B-cell lymphoma. A detailed note setting out my findings and addressing the contribution made to the cause of his death by a mixture of factors is provided together with this letter.

Coroner's legal powers and public interest

One of the ways in which an inquest can serve the public interest is by drawing attention to the existence of circumstances which, if left unremedied, might lead to further deaths. To that end, Rule 12 of the Inquest and Post-mortem Examinations (Jersey) Law 1995, permits me to report matters to the relevant person or authority with a view to preventing the recurrence of fatalities like that in question at the inquest.

At the conclusion of the inquest into Mr Tinley's death, I announced that I would be writing a report to prevent future deaths addressed to you in your capacity as Minister for Health as I believe that you can address the issues raised by this report.

Summary of Findings

Mr Tinley died on 6 January 2025 of high-grade B-cell lymphoma. The inquest heard evidence that, while his underlying cancer had a poor prognosis, a series of systemic failings led to Mr Tinley not being informed of the return of his lymphoma and delays in initiating appropriate treatment. These delays cumulatively amounted to nearly five months of lost clinical intervention time.

A critical failure occurred when the relevant Consultant Haematologist left post shortly before a set of CT scan results were received in January 2024. No system existed at that time to ensure that incoming results were reviewed, escalated, or acted upon. Consequently, the Haematology Department did not treat the case as an active referral until Mr Tinley's GP wrote to them several weeks after the CT Scan results were received.

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By the time Mr Tinley was seen by a Haematology Consultant in May 2024, his lymphoma had infiltrated several of his organs. Expert evidence indicated that although earlier intervention might not have changed his ultimate prognosis, it could have afforded significantly better palliation, including greater control of tumour progression and reduced severity of symptoms which were distressing both for Mr Tinley and his family. The delay in treatment therefore contributed to the timing and manner of his death.

The inquest heard evidence that Mr Tinley's care was adversely affected by systemic failings rather than individual errors. Key systemic weaknesses included the absence of effective safety-netting procedures for tracking investigation results when clinicians leave post, an absence of standard operating procedures for suspected or relapsed lymphoma, and inconsistent communication of results across services through multi-disciplinary teams (MDTs). Evidence was presented to the inquest that several of these failings are in the process of being addressed.

Coroner's Concerns and Recommendations

One of the difficulties that was recognised in Mr Tinley's case was with accessing complete medical records, because records are being held partly on paper and partly electronically, creating a fragmented clinical picture. Both an external expert, Professor Roche, and the Deputy Medical Director gave evidence that a lack of integration between electronic record systems used by different teams in the hospital and primary care, and the use of both electronic and paper record keeping simultaneously, impeded timely decision-making and contributed to the failure to act on important test results.

The evidence presented to the inquest was that this issue is not limited to the diagnosis and treatment of lymphoma and that there is a risk of similar delays arising in other cases. Since the inquest was heard my office has received correspondence from two other families raising similar concerns about the care their loved ones received prior to their deaths and failures in communication between clinicians and between the hospital and patients.

The inquest heard evidence that work to upgrade hospital IT systems is ongoing and that there are plans to stop creating paper notes and establish an electronic Jersey Single Patient Record, which may reduce the risk that failures in communication will cause similar fatalities in future.

To prevent future deaths like Mr Tinley's, I recommend that the Minister for Health consider whether work can be expedited to ensure that medical records prepared by

different primary and secondary care services are processed, stored and shared in a manner that enables timely and appropriate access for all healthcare professionals. This has the potential to ensure that incomplete or fragmented records do not impede clinical decision-making or delay treatment as they did in Mr Tinley's case.

Yours sincerely,

Advocate Matt Berry

Deputy Viscount