REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: NHS England
1	CORONER I am Alison Mutch, HM Senior Coroner, for the coroner area of South Manchester
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 3rd May 2023 I commenced an investigation into the death of Anthony Eric Williams. The investigation concluded on the 27th September 2023 and the conclusion was one of **Narrative: Died from the complications of bowel cancer not diagnosed and not treated until it had reached an advanced stage.** The medical cause of death was **1a) Metastatic Adenocarcinoma of the bowel**
4	CIRCUMSTANCES OF THE DEATH Anthony Eric Williams presented at Tameside General Hospital with abdominal pain and was diagnosed with constipation on 7th October 2022.On 12th October a telephone consultation with a GP resulted in further discussion of treatment for constipation. On 3rd November he was found by the GP to have a distended abdomen and was referred on the two-week cancer pathway. CT scans found a mass in his bowel. Biopsies were initially inconclusive for cancer. A PET scan on 8th February confirmed advanced colorectal cancer. A stoma was inserted laparoscopically on 14th February to assist with his bowel symptoms. He was not seen for chemotherapy consideration until 6th March 2023. His health had deteriorated significantly since his referral on the cancer pathway and his suitability for chemotherapy was borderline. The plan was to start it around 17th March. In the period he developed spinal cord compression and received radiotherapy which was given on 21st March. He continued to deteriorate with the cancer having spread into his brain. Chemotherapy was not started until 4th April 2023.He deteriorated rapidly with the cancer having spread aggressively. He died at Stamford Court on 28th April 2023.

5	CORONER'S CONCERNS During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will 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 a national shortage of specialist scanning facilities such as was required in Mr Williams' case meant that there were delays nationally with the diagnosis of cancers. This in turn led to delays in treatment and poorer outcomes for cancer patients as delays in diagnosis meant that the cancer would often have advanced further, and treatment was less likely to be successful. This was compounded by the fact that additional complications such as cord compression could arise whilst a scan was awaited and that the patient would be less able to cope with treatment such as chemotherapy when it ultimately started. The inquest also heard evidence that there were significant delays nationally in compliance with the two-week cancer pathway which led to poorer outcomes for patients as any delay in treatment reduced the likelihood of a successful outcome. Evidence was also heard that the delay Mr Williams faced between diagnosis and being seen for a plan to be developed was also part of a wider national picture of delay in accessing cancer treatments and again reduced the chances of a successful treatment outcome.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you 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 26th January 2024. 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 namely [redacted] on behalf of the Family, who may find it useful or of interest.

	I am also under a duty to send the Chief Coroner a copy of your response. 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	**Alison Mutch** **HM Senior Coroner**  **01.12.2023**