Kate Robertson
Assistant Coroner for North Wales (East and Central)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Betsi Cadwaladr University Health Board (BCUHB)
1	**CORONER** I am Kate Robertson, Assistant Coroner for North Wales (East and Central)
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 6 December 2022 an investigation was commenced into the death of Thomas Grenville Hammersley Ithell (DOB 24/4/45) who died on 20 November 2022. The investigation concluded at the end of the inquest on 17 January 2024. The conclusion of the inquest was natural causes.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are as follows :- Thomas Ithell was aged 77 at the time of his death on 20 November 2022. He was diagnosed with prostate cancer in September 2017 and biopsies revealed bilateral adenocarcinoma of the prostate. He underwent radiotherapy in 2018 and hormone deprivation treatment. From April 2021 onwards his PSA levels increased periodically. In October 2021 his level was 5.5ng/ml having been 1.5ng/m lin April 2021 and 2.7ng/m in July 2021 indicating a recurrence of the cancer and likely incurable. Thomas Ithell was reluctant to undergo further hormone treatment as he found tolerating the side effects difficult. He did not then have his PSA levels tested after November 2021 and was not reviewed at all due to becoming missed to follow up. After he had been seen by the nurse practitioner on 5 November 2021 the letter written by the nurse practitioner for advice from the consultant did not reach the consultant. He was reviewed by a consultant on 22 October 2022 after an urgent suspected cancer GP referral following routine set of blood tests in September 2022, some 10 months later. Mr Ithell died in hospital on 20 November 2022 having been admitted with shortness of breath, the malignancy having caused his death.

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 – During the course of the evidence it was identified that:- 1. There was no Datix raised by anyone when the error (Mr Ithell being lost to follow up) was identified, either at the time of the appointment on 22 October 2022 when the error was identified or at any point thereafter; 2. There has been no investigation by the Health Board into how Mr Ithell came lost for follow up after his appointment on 5 November 2021; 3. There have been no assurances as to what, if any, changes and learning have been identified other than a tracking system for PSA monitoring; 4. Evidence was heard at the Inquest that time restraints on hospital staff had meant that Datix was not completed and that the system was not user-friendly. I have raised a number of Prevention of Future Death reports with the Health Board previously around investigation processes. I remain incredibly concerned that where matters are not raised in accordance with internal Health Board processes that assurances given to me previously in Prevention of Future Death Reports cannot be supported. Furthermore, I am concerned that Datix reports will not be raised if time constraints prevents such, where the Health Board themselves often identify the Datix reporting system as the initiation of governance / investigation processes.
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 18 March 2024. I, Kate Robertson, 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 Family of the Deceased and to the Chief Coroner. 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	Dated 22 January 2024  Signature Assistant Coroner for North Wales (East and Central)