Cyfeiriad Dychwelyd/ Return Address:
Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
Pencadlys
Parc Navigation,
Abercynon
CF45 4SN

Cwm Taf Morgannwg
University Health Board
Headquarters
Navigation Park
Abercynon
CF45 4SN

Ffôn/Tel: [redacted]

Eich cyf/Your Ref:
Ein cyf/Our Ref:
Ebost Email: [redacted]
Dyddiad/Date: 8 November 2024

Mrs Patricia Morgan
Area Coroner
South Wales Central
Coroner's Office
The Old Courthouse
Courthouse Street
Pontypridd
CF37 1JW

Dear Mrs Morgan

Regulation 28 Report to Prevent Future Deaths

I am writing in response to the Regulation 28 Report issues to Cwm Taf Morgannwg University Health Board (CTMUHB) on 17 September 2024 following the conclusion of the inquest into the death of Sara Grinnell.

The Health Board values the opportunity to learn from the tragic events relating to Sara's death. The Regulation 28 report identified three key areas of concern listed below:

(1) Following an ultrasound scan performed in June 2019, and urgent referral to the Gynaecology Department, there was extensive delay in excess of 22 weeks to contact the patient with an urgent appointment.
(2) The means of contacting the patient for an Urgent Gynaecology appointment was via written correspondence without further consideration of other means via telephone, email, or via G.P.
(3) When the G.P. re-referred the patient to the Gynaecology Department due to ongoing and worsening symptoms, there was a lack of regard to earlier referrals and the extensive delay that had already occurred and a missed opportunity to escalate the urgency of contact.

As a consequence, this resulted a significant delay of 24 months between the urgent referral to Gynaecology Department and eventual diagnosis.

This response is limited to the actions taken by CTMUHB in relation to the Coronial concerns, each of which will be responded to individually in order to provide assurance on the improvement actions implemented.

1) **Following an ultrasound scan performed in June 2019, and urgent referral to the Gynaecology Department, there was extensive delay in excess of 22 weeks to contact the patient with an urgent appointment.**
The Welsh Government has established clear guidelines for managing referral-to-treatment waiting times to ensure timely access to care. Under the mandate issued in December 2009, all referrals to secondary care are expected to be addressed within 26 weeks for at least 95% of cases.

   Ms. Grinnell's waiting time of 22 weeks, though understandably lengthy, was within the official timeframe for urgent cases. It is important to note that only a referral marked as "urgent suspected cancer" would have triggered a more accelerated pathway in line with NHS guidelines, designed to expedite diagnosis and treatment for cases suspected of malignancy.

   With the benefit of hindsight, it might have been beneficial for Ms. Grinnell's referral to have been designated as "urgent suspected cancer" initially, which may have allowed for management under the national single cancer pathway for endometrial cancer.

2) **The means of contacting the patient for an Urgent Gynaecology appointment was via written correspondence without further consideration of other means via telephone, email, or via G.P.**

   Our primary communication method with Ms. Grinnell has consistently been written correspondence. We made three documented attempts to reach her on November 21st, November 28th, and December 12th, 2019. Historically, written communication has been effective, as evidenced by Ms. Grinnell's response to a January 2018 letter, which she received and then attended the scheduled appointment.

   Following her GP's urgent suspected cancer referral, we continued to communicate primarily by letter, a method proven both adequate and effective in delivering essential information. Additionally, on May 28th 2019, there is documented evidence of a telephone conversation between Ms. Grinnell and hospital management, which occurred shortly after her urgent referral to secondary care, following the 24-hour response protocol.

   There is no indication that an alternative communication method would have increased Ms. Grinnell's likelihood of attending any appointments during 2019–2020, particularly given the heightened difficulties posed by the pandemic. It is also notable that from January 2019 to December 2020, Ms. Grinnell did not initiate contact with her GP. Her next recorded contact with the GP occurred in January 2021.

3) **When the G.P. re-referred the patient to the Gynaecology Department due to ongoing and worsening symptoms, there was a lack of regard to earlier referrals and the extensive delay that had already occurred and a missed opportunity to escalate the urgency of contact.**

The Health Board respectfully does not agree. Following Ms. Grinnell's referral for worsening symptoms, her case was reviewed by both her GP and a specialist, who determined that her symptoms did not meet the criteria for an urgent suspected cancer (USC) referral. Despite this assessment, multiple attempts were made to contact her. Ultimately, Ms. Grinnell was removed from the waiting list due to a period of non-engagement with healthcare providers.

A letter dated 12th December 2019, sent to both Ms. Grinnell and her GP, explicitly stated that should her condition become a renewed concern, she could be reinstated on the waiting list within three months. This correspondence provided both Ms. Grinnell and her GP with a direct telephone number for the booking office, should re-engagement be necessary. The letter reflects a proactive approach, carefully considering her symptoms and incorporating safety-netting measures to mitigate the risk of a missed follow-up opportunity.

As no further contact was made by Ms. Grinnell or her GP within the specified period or throughout 2020, it is reasonable to conclude that she exercised her autonomy in choosing not to seek further care—a decision that healthcare providers must respect.

The Health Board would like to reiterate that no communication was received from Ms. Grinnell or her GP until January 2021. In our view, the period before January 2021 represented the critical window for early intervention. However, the missed opportunity here is multifactorial, influenced by apprehension about hospital visits during the COVID-19 pandemic and the challenges in healthcare delivery due to pandemic-related pressures.

As a Health Board, we endeavour to achieve required standards of care for women. An improvement plan for Urgent Suspected Cancer referrals has been developed and included within this response for assurance.

I hope that this response provides explanation and assurance that CTMUHB are committed to fully address the concerns in the Regulation 28 Report relating to Sara Grinnell's death.

Please do not hesitate to contact Dr Dom Hurford, Executive Medical Director if you would like further assurances or if you require a meeting to discuss any areas of continuing concern.

Yours sincerely

[redacted]

[redacted]

Prif Weithredwr/Chief Executive

CTMUHB Improvement plan

Action	Impact
Capital investment	
Opening of Gynae Hub at RGH	The Gynae Hub passed through three stages until it is fully operational since July 2024. It includes Gynae Day Assessment Unit (GDAU) and Early Pregnancy Unit (EPU); the rapid access cancer service (GRAS); hysteroscopy and colposcopy services; several outpatient clinics; increase in urgent gynaecology services and ultrasound scanning facilities. This increased our capacity in CTM, offered multiple services as one shop floor, markedly improved women experience and reduced unnecessary delays. This facility will also create an opportunity to bring Bridgend locality patients through the GRAS cancer service.
Purchase of additional examination bed (compatible with ultrasounds scanning)	Additional scanning capacity will provide flux in the system to increase the number of UCS USS when an increase in referrals is seen. When referrals are reduced scans will be utilised for urgent review, or stage 2 routine patients. Increase by 4-5 scan sessions per week; three of them will be dedicated for USC patients with extra capacity of 18 patients per week
Purchase of additional ultrasound scanner	Additional scanning capacity will provide flux in the system to increase the number of UCS USS when an increase in referrals is seen. When referrals are reduced scans will be utilised for urgent review, or stage 2 routine patients. Increase by 4-5 scan sessions per week; three of them will be dedicated for USC patients with extra capacity of 18 patients per week. In addition to creating 4 extra one stop clinics (scan and assessment) with capacity of 40 patients per month.
Develop extra scan clinics to tackle the back log created as a result of sonographer sickness and reduced activity	Additional ultrasound scan clinics for USC waiting patients. Extra one stop (scan and assessment clinics with capacity of 10 women per clinic). This brought our waiting time for 1st outpatient appointment to around 10 days.
Develop extra Hysteroscopy sessions in the newly developed Hub (in process)	Additional hysteroscopy sessions will expand the existing Gynae Cancer Rapid access service (GRAS), creating enough capacity to repatriate Bridgend PMB USC cases back to CTM.
Process improvements	

Improve triaging process; update the triage proforma, agreement of daily triage allocation; implementation of electronic triage (WPRS)	Update triage form to include correct process for GRAS and non-USC hysteroscopy referrals. To ensure triage is done within 24-48 hours consistently. Electronic triage (in process) will make allocation of triage duty far easier from any site, improving cover for leave etc and ensuring timely triage.
Establish CTM Gynae cancer oversight meetings (implemented from 11th May)	Gynaecology directorate hold internal care group meetings (across all sites) to discuss cancer performance, review the patients, address escalations etc. The anticipated impact is improved communication across sites, particularly in terms of tracking, care plans for malignant patients, addressing long waits and ensuring timely dates for diagnostic and treatment procedures.
Improve MDT attendance and performance	Improved clinical oversight of patients listed for MDT; timely treatment plans; improved collaborative working with rad and path teams; reduce delays for agreement of further diagnostic or treatment plans.
Rota for CNS to ensure daily review of patients admitted with cancer in PCH with improved communication with the on call team	Ensure continuity of care for women admitted with cancers. Improve the communication and the plan of care for our women.
Improve harm review process	Ensure robust clinical MDT review of patients waiting >104 days
Workforce improvements	
Secure administrative support for expansion of the Gynaecology Rapid Access service (GRAS) to include Bridgend population (patients presented with postmenopausal bleeding are current seen at NPTH)	Administrator is essential to provide co-ordination to the expansion of the GRAS service, including all booking of appointments, working across CTM and SB PAS systems to outcome patient pathways, liaising with medical records, consultants, secretaries, cancer teams, CNS, radiology and pathology across sites.
Re-banding of EPU nurse to become nurse sonographer	Additional scanning capacity provided flux in the system to increase the number of UCS USS when an increase in referrals is seen. Extra capacity is utilised for urgent review, or stage 2 routine patients.

Appoint team leader for Gynae Hub (nursing)	The team leader will oversee all activity in the Gynaecology Hub, ensuring appropriate staffing cover, efficient use of resource etc. This appointment will release the nurse hysteroscopist to undertake more clinical duties.
Appoint cancer tracker for Gynae services to improve efficiency across sites	Improved tracking for Gynae services across sites.
Repatriate Service Level Agreement with SBUHB	Improve access to women living around Bridgend locality which will reduce the waiting times for the 1st outpatient appointment and help to manage women around Bridgend locality to be treated in the standard required time frames.