GRAEME HUGHES

HIS MAJESTY'S
SENIOR CORONER

SOUTH WALES CENTRAL
CORONER AREA

CORONER'S OFFICE
THE OLD COURTHOUSE
COURTHOUSE STREET
PONTYPRIDD
CF37 1JW

Telephone: [redacted]
Email: [redacted]

ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive Cwm Taf Morgannwg University Health Board**
1	**CORONER** I am **Patricia Morgan Area Coroner**, for the coroner area of South Wales 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 22 April 2022 I commenced an investigation into the death of Sara GRINNELL . The investigation concluded at the end of the inquest 17/09/2024 . The conclusion of the inquest was Ms Grinnell died as a result of the progression of endometrial cancer. There were delays in investigating her symptoms which may have identified potential treatment options at an earlier stage. **1a Metastatic Endometrial Cancer** **1b** **1c** **II**
4	**CIRCUMSTANCES OF THE DEATH**

	These were recorded as :- Mrs Grinnell had been suffering with excessive vaginal bleeding since 2015. She suffered with significant menorrhagia from around 2018 and had a cervical poly removed in 2018. She was referred to the Gynaecology Department in 2019 due to the ongoing menorrhagia. An ultrasound scan performed in June 2019 resulted in an Urgent referral to the Gynaecology Department. She was sent 2 letters by the gynaecology department approx. 22 weeks after the Urgent referral, however it appears that Sara Grinnell did not receive the letters. She was referred again in Aug 2020, Jan 2021, and in May 2021 she was referred under the Urgent Suspected Cancer pathway. In June 2021, Ms Grinnell was diagnosed with endometrial cancer. A planned hysterectomy on 10 September 2021 was postponed due to insufficient theatre time. Her treatment options were limited to palliative. She sadly died on 11 April 2022 at Princess of Wales Hospital. She deteriorated, and passed away on 11/4/22 The Inquest focused upon:- a. The timeline of referrals to and appointments with the Gynaecology Department and investigations that took place b. The treatment received by Mrs Grinnell .
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. (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 in attempting 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. (3) As a consequence, this resulted a significant delay of 24 months between the urgent referral to Gynaecology Department and eventual diagnosis.

[redacted]

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 12th November 2024. Only 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 family who may find it useful or of interest. I have also sent a copy to the Chief Executive of Swansea Bay University Health Board 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	17 September 2024 **SIGNED:** P C Morgan Patricia Morgan Area Coroner for South Wales Central Coroner Area

[redacted]