Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **The Secretary of State for Health and Social Care**
1	**CORONER** I am Samantha GOWARD, Area Coroner for the coroner area of Norfolk
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 15 June 2023 I commenced an investigation into the death of Carla Marie SMITH aged 38, date of death 07 June 2023. The investigation concluded at the end of the inquest on 24 January 2025. **The medical cause of death was:** 1a) Metastatic Endometrial Cancer 1b) 1c) 2) **The conclusion of the inquest was:** Died due to a naturally occurring condition, a rapidly progressing cancer, the diagnosis and treatment of which was delayed due to a number of missed opportunities.
4	**CIRCUMSTANCES OF THE DEATH** Carla Smith had a history of excessive vaginal bleeding. She first attended her GP surgery in July 2022 and an ultrasound scan was arranged. The report received 23 August 2022 showed a thickened endometrium of 22 millimetres. This should have led to a referral to the gynaecology team. After a review by a different GP and a discussion with Carla on 27 September 2022, an urgent referral was made with an anticipated wait of 4-6 weeks. When triaged by specialists at the hospital, the referral should have been upgraded to a 2 week wait pathway. Carla was not seen until 31 January 2023. A biopsy on that day was marked as routine instead of 2 week wait. There was a delay in the sample being processed and this was chased after Carla attended hospital again as an emergency on 15 April 2023 due to ongoing heavy bleeding. A CT scan showed signs suggestive of advanced endometrial malignancy with disseminated metastasis. This prompted a report on the January biopsy, which was said to show grade 1 womb cancer at that time. After a further biopsy and investigations in April 2023 it was felt that Carla had stage 4 cancer. While an initial plan was made for surgery, due to the unusually aggressive nature of the cancer, Carla rapidly deteriorated and was sadly not suitable for surgery and palliative care commenced. She died on 7 June 2023. During the course of the Inquest, it was apparent that there were a number of missed opportunities to refer Carla for treatment and to use the correct pathway to do so and there were also significant delays in receiving results from the laboratory and due to lengthy

	waiting lists, even for urgent referrals.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could 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. During the course of the evidence, I heard from Consultants at two hospitals, and read evidence from others. The evidence I heard is that, at that time there were significant waiting lists, even for those on an urgent pathway. I heard that these issues persist and that, in relation to gynaecology referrals which was the subject of this inquest, where the expected waiting time would previously be 4-6 weeks for an urgent referral, one hospital has a waiting time of 18 weeks, the other 30 weeks (and 60 weeks for routine). I was advised by one Consultant that they do not know how they can catch up with this backlog. I am aware that this is not a problem that is unique to just the two Trusts from whom evidence was heard. 2. The cause for concern is that some patients may significantly deteriorate while on such lengthy waiting lists. In some cases, this may mean that they lose some treatment options due to their condition advancing. This leads to a risk of future deaths. 3. The other concern I have following the evidence heard, is that if someone is on a routine or urgent waiting list, there is no requirement or system in place to monitor their progress. I was advised that those referred under a 2 week wait (which I am now advised has been changed to a 28 day wait) for suspected cancer, will be monitored to ensure that the timescale is met. There is no such requirement for the other waiting lists. This may lead to patients being left waiting for excessive periods, without any requirement for their case to be reviewed to ascertain if it remains suitable for such a lengthy wait, or if a new referral needs to be made on a different pathway.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 March 26, 2025. 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 Carla's mother and partner Norfolk and Norwich University Hospitals NHS Foundation Trust The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust Heacham Group GP Practice I have also sent it to CQC

	HSSIB, Healthwatch NHS England & NHS Improvement. who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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: 29/01/2025**  **Samantha GOWARD** **Area Coroner for Norfolk** County Hall Martineau Lane Norwich NR1 2DH