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:** **CHIEF EXECUTIVE ABMU HEALTH BOARD** **1 TALBOT GATEWAY** **BAGLAN ENERGY PARK** **BAGLAN** **PORT TALBOT** **SA12 7BR**
1	**CORONER** I am **Aled Gruffydd**, Senior Coroner, for the coroner area of SWANSEA NEATH & PORT TALBOT
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 the 19th of June 2024 I commenced an investigation into the death of Gareth Wynne Tatchell. The investigation concluded at the end of the inquest on the 26th June 2025. The medical cause of death is 1a) pneumonia 2 squamous cell carcinoma The conclusion of the inquest as to how Mr Tatchell came to his death was a narrative conclusion and is as follows:- the deceased died from the natural cause of pneumonia having undergone treatment for squamous cell carcinoma which had returned at the time of death. The delay in providing treatment more than minimally contributed to the deceased's death.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was Gareth Wynne Tatchell and he was pronounced dead on the 9th April 2024 at Princess of Wales Hospital, Swansea. The cause of death was pneumonia. Squamous cell carcinoma was a contributing factor in his death. Gareth was referred to the maxillo-facial team at Morriston Hospital on the 12th of April 2023 by his dentist following the discovery of an ulcer in the lower left mandible. The referral was classed as an urgent suspected cancer (USC) and Gareth was seen in outpatients clinic on the 28th of April 2023. Cancer was suspected at that point, specifically a squamous cell carcinoma but it needed to be confirmed by a biopsy. That

	biopsy took place on 18 May and the result came back on 30 May as a moderately differentiated squamous cell carcinoma. Gareth was seen again on the 19th of June and further tests consisting of a CT of the thorax, a CT angiogram of the legs and an MRI and ultrasound of the neck were undertaken on the 28th. Care was then transferred to the treating consultant maxillofacial surgeon who first saw Gareth on the 6th of July, and then on the 27 July to discuss treatment, which would consist of surgery and radiotherapy. Due to theatre capacity, the earliest date being 13 September. By the week prior to surgery Gareth had developed a lump both inside and out, meaning that the lump was visible on the outside but it would also have spread to the blood vessels in the neck. The surgery was able to remove the tumour macroscopically i.e all that was visible to the naked eye, but as it was encasing the carotid it would not be possible to remove it all. In February 2024 the treating consultant saw Gareth in hospital after he had gone in to have the AAA repaired. It was then that Gareth complained of a pain in the neck which prompted the CT scan showing an enlargement and a biopsy then confirmed that the cancer had returned. Gareth was discharged from hospital following the AAA repair but was readmitted to hospital on the 8th of March 2024. He subsequently passed away in hospital on the above date.
5	**CORONER'S CONCERNS** During the course of the inquest it transpired that the Suspected Cancer Pathway introduced for the whole of Wales in 2019 required a suspected cancer to be diagnosed and staged within 31 calendar days of the date of referral and for treatment to commence within 62 calendar days from the date of referral. In this case the diagnostic and staging phase was completed in 97 days from the date of referral and treatment commenced within 144 days of the date of treatment. The result of that delay was that it made the carcinoma more difficult to treat in that it would not have had the extracapsular spread or the encasement of the carotid that was witnessed at the end of August and which was not present around the end of June when treatment ought to have taken place. Had the timescales had been complied with then treatment would have been administered before extracapsular spread had occurred. Evidence was received from the treating consultant that this contributed towards Gareth's death. Evidence was heard that since this incident there had been an improvement in theatre capacity with additional theatre sessions having been allocated to oral and maxillofacial surgery, and an additional Consultant Maxillofacial Oncological Surgeon has been appointed to undertake both surgery and outpatient appointments. The evidence could not point to improvements in radiology services however, which is needed to undertake staging scans. This case underwent staging scans in May 2023, however as recently as May 2025 a letter was sent to the Clinical Lead for Radiology by two Associate Medical Directors expressing concerns that delays to staging scans are causing unnecessary risk in aggressive cancers that are at risk of progression and irresectable. I am concerned that delays in undertaking staging scans are allowing such cancers to progress to the point that they are irresectable, resulting in poor prognosis for patients and reducing survivability rates and life expectancy and 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. There was a delay in both the diagnostic and staging phase and treatment phase contrary to the timescales in the Suspected Cancer Pathway. 2. Part of the delays resolve around the time taken to undertake staging scans for

	the purpose of the diagnostic and staging phase. 3. Two Associate Medical Directors have communicated that delays in undertaking staging scans are ongoing and are having an impact on survivability rates and prognoses by making treatable cancers irresectable.
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 22 September 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 [redacted]. 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	 **28 July 2025 HM SENIOR CORONER ALED GRUFFYDD**