**GRAEME HUGHES**

**HIS MAJESTY'S SENIOR CORONER**

**SOUTH WALES CENTRAL CORONER AREA**

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

[redacted]

**ANNEX A**

## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**The Minister for Health and Social Services of Wales,** [redacted]<br><br>[redacted] **Chief Executive of Digital Health & Care Wales** |
| 1 | **CORONER**<br><br>I am **Rachel Knight H M Coroner**, for the coroner area of South Wales Central. |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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** |

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| | On 26 November 2024 I commenced an investigation into the death of Milos JANKOVIC. The investigation concluded at the end of the inquest on 18/09/2025. The narrative conclusion of the inquest was that Mr Jankovic had been diagnosed with Barrett's Oesophagus in 2014, but lost to follow up surveillance due to a bowel cancer taking priority. Sadly, in 2024 he began to show symptoms of cancer and testing established that he had developed brain metastases of a primary oesophageal cancer.<br><br>Had Mr Jankovic been under surveillance, it is more likely than not that he would have by 2023, been seen by specialists in Barrett's Oesophagus who would have been able to offer various options for ongoing surveillance and potential treatments. However, there is insufficient evidence that this would have changed the outcome for Mr Jankovic, given the nature of the disease and its known poor outcomes despite surveillance.<br><br>**1a Metastatic Oesophageal Cancer**<br><br>**1b Barrett's Oesophagus**<br><br>**1c**<br><br>**II** |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>The Inquest focused upon:-<br><br>a. The practical aspects of administration of surveillance for Barrett's patients in primary and secondary care; and<br><br>b. Whether the outcome would have been different for Mr Jankovic if surveillance had occurred as it should have<br><br>. |
| 5 | **<u>CORONER'S CONCERNS</u>**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. |



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| | (1) There are two cases that have recently come to my attention within the Cardiff area where patients have been diagnosed with Barrett's, lost to follow-up and have gone on to die from oesophageal cancers;<br><br>(2) There are inadequate processes in place to address this lacuna, particularly in primary care where a patient may not be a regular attender;<br><br>(3) GPs frequently recall their patients with known, chronic issues such as asthma & diabetes, and there is a process for recalling women for smear tests for example, however Barrett's does not currently benefit from such a recall exercise/audit, even though it is well-established to be a pre-cancerous condition; and<br><br>(4) When prescribing drugs such as omeprazole or other PPIs for symptoms which may relate to Barrett's, there is no prompt for GPs to consider whether the patient hits the relevant red flags which may benefit from endoscopy rather than a course of medication, or whether they have previously been diagnosed with the condition and ought to be under surveillance. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you and your organisations have the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 26th November 2025. I, the Coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to family and Mr Jankovic's GP who may find it useful or of interest.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>The Chief Coroner may publish either or both in a complete or redacted or summary form. She may send a copy of this report to any person who she 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 |



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| | publication of your response by the Chief Coroner. |
| 9 | 1st October 2025<br><br>**SIGNED:**<br><br>[redacted]<br><br>Rachel Knight H M Coroner for South Wales Central Coroner Area |