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:** **1 Chief Executive Of Aneurin Bevan University Health Board** **2 Chief Executive Of Velindre University Nhs Trust**
1	**CORONER** I am Caroline SAUNDERS, Senior Coroner for the coroner area of Gwent
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 07 August 2024 I commenced an investigation into the death of Steven Paul TURZYNSKI aged 70. The investigation concluded at the end of the inquest on 25 September 2025. The conclusion of the inquest was recorded as: Death from Natural Causes The medical cause of death was: 1a) Pneumonia 1b) Metastatic Squamous cell Carcinoma of the Lung 2) Oropharyngeal Cancer (treated) Steven Paul Turzynski died from the effects of lung cancer at the Grange University Hospital, Llanfrechfa on 29/7/2024.
4	**CIRCUMSTANCES OF THE DEATH** Steven Paul Turzynski was a 70-year-old man who had successfully undergone treatment for oropharyngeal cancer in 2019. The nature of the cancer affected Steven's ability to eat and to enjoy food. In January 2023, Steven was diagnosed with lung cancer. His treatment thereafter further affected his ability to maintain adequate nutrition. Steven's dietetic care was shared between Aneurin Bevan University Health Board and Velindre University NHS Trust. Steven was under the care of dietitians in both departments at the same time. However, through the course of his treatment from November 2023 until his death in August 2024, there was very little communication between the two teams and no sharing of information or discussion about treatment plans. Steven required ongoing nutritional support and was on occasion receiving different advice from these two teams. The poor communication was further hampered by an inability for the respective teams to access each other's records.

	The inquest was told that adequate nutrition could not be determined merely from recordings of a person's weight or their alleged intake, but required an assessment of frailty and cachexia, matters which needed to be assessed in person. Throughout this time, Steven had only 2 face to face appointments with members of the dietetics department By the time of his death Steven was suffering from significant undernutrition.
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: (brief summary of matters of concern) Steven Paul Turzynski died from the effects of cancer, which was also responsible for his nutritional status. However the almost absent communication between the two dietetic teams and the lack of adequate assessment during the last 12 months of Steven's life contributed to his poor nutritional state. I was informed at the inquest that the need for a face to face appointment is entirely a matter for the individual dietician. However, this decision making is not governed by guidelines nor is it monitored and can lead to an over-reliance of telephone assessments. Adequate nutrition for patients who have cancer is a significant element of their care and inadequate nutrition can contribute to an early death. Kindly inform me whether your organisations have taken steps to improve co-working within disciplines when sharing the care of patients who require hospital and community dietetic care. Kindly inform me whether action will be taken so that when care is shared, the respective teams can access each other's records. Kindly inform me whether there are plans for setting guidelines or monitoring the adequacy of dietetic assessments over the phone, and a minimum standard set for face to face consultations.
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 December 01, 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 **Family And/Or Next Of Kin Of Steven Paul Turzynski**

	I have also sent it to **Health Inspectorate Wales** 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: 06/10/2025** [redacted] **Caroline SAUNDERS** **Senior Coroner for** **Gwent**