Kate Robertson
Assistant Coroner for North Wales (East and Central)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Chief Executive, Betsi Cadwaladr University Health Board
1	**CORONER** I am Kate Robertson, Assistant Coroner for North Wales (East and 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 16 August 2024 an investigation was commenced into the death of Rory Colin Williams (DOB 18/7/1979) who died on 10 August 2024. The investigation concluded at the end of the inquest on 7 January 2025. The conclusion of the inquest was that death was due to natural causes.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are as follows :- Rory Colin Williams was referred to the Gastroenterology service at Ysbyty Glan Clwyd (part of the Betsi Cadwaladr University Local Health Board) on 22nd May 2023 by his General Practitioner under an urgent suspected cancer pathway due to suffering with symptoms of dysphagia and weight loss. Despite multiple attempts by the service to contact Mr Williams via telephone and written communications, Mr Williams did not attend an outpatient appointment scheduled for 17th August 2023. Mr Williams attended an initial endoscopy on 1st October 2023. This revealed severe oesophagitis. Mr Williams found it difficult to tolerate the procedure, however, and in view of this and the noted severe oesophagitis, it was recommended that the procedure be repeated on 18th November 2023. However, Mr Williams did not attend this appointment. A follow-up letter in December 2023 informed Mr Williams that due to his non-attendance he was being discharged back to his General Practitioner, but advised Mr Williams to arrange the repeated endoscopy if he wished to proceed with this.

	On 17th April 2024, Mr Williams re-engaged with healthcare services after presenting to the Emergency Department at Ysbyty Glan Clwyd with chest pain. Mr Williams was referred for an outpatient endoscopy. The endoscopy, conducted on 30th July 2024, identified adenocarcinoma. On 8th August 2024, Mr Williams was admitted to Ysbyty Glan Clwyd with severe abdominal pain and passed away on 10th August 2024, whilst still being cared for in hospital.
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 – It was accepted by the Health Board that there had been a delay between April 2024 and July 2024 in undertaking the endoscopy. Whilst this did not impact on the outcome for Rory Williams it did highlight a number of ongoing concerns with the gastroenterology / endoscopy service:- a. Staffing – the evidence at Inquest was that the Health Board was struggling to maintain this most basic service at Ysbyty Glan Clwyd due to staffing issues which included lack of consultants, endoscopists and other essential healthcare staff. There is currently only one full time equivalent consultant and 3 locums. The service is currently considered to be 'absolutely dependent on locums'. It was noted that recruitment into gastroenterology is a challenge yet these issues have been ongoing for many considerable years, potentially since 2018. b. Infrastructure – evidence was heard that this requires significant investment and improvement within the service, and despite business cases having been made there have not been significant steps to improve this. It is not known why. c. The Health Board's target for urgent suspected cancer referrals to endoscopy (that is from GP referral to endoscopy) is 21 days. Today, this stands at 8 weeks. d. The Health Board's current wait time for urgent referrals (non-suspected cancer) to endoscopy is currently 89 weeks. This figure has increased since 2023. e. The Health Board's current wait time for routine referrals to endoscopy is currently 148 weeks. This figure has increased since 2023.

	f. I am concerned that there is no fully networked service for endoscopy / gastroenterology where this and the above concerns do not appear on the corporate risk register. Whilst they appear on the local risk register it is extremely concerning that corporately it does not appear as a risk. Evidence was heard that at one point the risk score for the service was reduced from 25 to 20. The reason is not known. g. The overall impression is that the service is not fit for purpose and that all of these concerns, many of which have existed for several years, signify a risk of harm and death of patients into the future as a result.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 10 March 2026. I, Kate Robertson, 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 Family of the Deceased, [redacted], Cabinet Secretary for Health and Social Care, and to the Chief Coroner. 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	Dated 13 January 2026 [redacted] Signature Assistant Coroner for North Wales (East and Central)