

**REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS
2013**

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's [PFD Publication Policy \(2026\)](#).

1.	CORONER I am Rose FARMER, Area Coroner, for the coroner area of Gwent.
2.	DATE OF REPORT 31 July 2026
3.	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.
4.	THIS REPORT IS BEING SENT TO 1. Cabinet Minister for Health and Care You are under a duty to respond to this report within 56 days of the date of this report, namely by September 25, 2026. I, the coroner, may extend the period if an appropriate application is made.
5.	YOUR RESPONSE 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary .
6.	SUMMARY OF CORONER'S CONCERN The absence in Wales of any monitored ophthalmology follow-up waiting time

	standards despite the extensive backlog of ophthalmology surveillance patients waiting for follow up appointments.
7.	ACTION SHOULD BE TAKEN In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
8.	INVESTIGATION AND INQUEST On 12 December 2025 I commenced an investigation into the death of Alexander Charles MCDONALD aged 70. The investigation concluded at the end of the inquest on 29 July 2026. The conclusion of the inquest was that: On 30 November 2025, Alexander Charles McDonald died at the Grange University Hospital, Cwmbran, from the effects of metastatic choroidal melanoma.
9.	CIRCUMSTANCES OF DEATH In June 2022, Alexander Charles McDonald attended an urgent ophthalmology appointment at the hospital following a routine eye examination by his local optician, during which concerns were identified from the results of an eye scan. He was assessed by a Consultant Ophthalmologist, who determined that he should be reviewed again in six months. However, no follow-up appointment was received. In June 2023, Mr McDonald returned to his optician for his annual eye examination. Due to concerns arising from that assessment, an emergency same-day appointment was arranged, and he was seen in the Ophthalmology Department at the hospital. The findings were consistent with a very large choroidal melanoma. An urgent referral was made to an ocular oncology centre, where the diagnosis was subsequently confirmed. The evidence heard at the Inquest was that, had Mr McDonald been reviewed after 6 months as planned in January 2023, the melanoma would have been diagnosed at that time. The evidence further established that, following referral to the ocular oncology centre, treatment would have commenced within two to four weeks. Following the delayed diagnosis in June 2023, Mr McDonald underwent a number of treatments for the tumour. However, subsequent investigations revealed that the cancer had metastasised to his liver. Sadly, Alexander McDonald died on 30 November 2025.
10.	CORONER'S CONCERNS During the course of the inquest I heard evidence 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: There are substantial delays in ophthalmology follow-up appointments across

	Wales. Evidence received during the inquest indicated that there are currently approximately 140,000 ophthalmology follow-up appointments awaiting review in Wales, whilst there are approximately 65 consultant ophthalmologists providing services across Wales. Current ophthalmology capacity appears insufficient to meet the demand for follow-up surveillance. The evidence suggested that large numbers of patients requiring ongoing monitoring are not being reviewed within clinically intended timescales. There is no nationally reported or routinely monitored metric measuring the timeliness of ophthalmology follow-up appointments. Unlike first outpatient appointments, there appears to be no comprehensive national performance measure enabling identification of the extent to which follow-up patients are being seen within clinically required review periods. The absence of a robust national metric and oversight mechanism creates a risk that patients requiring surveillance for ophthalmic conditions may experience prolonged delays. Delay in ophthalmology follow up can result in delayed diagnosis of serious and life-threatening disease. This case demonstrates the impact of not having timely follow up appointments. Similar delays may place other patients at risk of delayed diagnosis of malignancy and death.
11.	COPIES AND PUBLICATION OF THIS REPORT I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: • Family members and NOK of deceased • **No Details Given** I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the

	publication of reports and responses.
12.	SIGNATURE  Rose FARMER Area Coroner for Gwent