John Adrian Gittins
Senior Coroner for North Wales (East and Central)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** BCUHB, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd LL57 2PW.
1	**CORONER** I am John Adrian Gittins, Senior 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 the 25th of May 2021 I commenced an investigation into the death of Trevor Reynolds (DOB 14.4.42 DOD 15.5.21). The investigation concluded at the end of the inquest on the 4th of May 2022. The conclusion of the inquest was a narrative in the following terms : "On the 3rd of May 2021, Mr Trevor Reynolds had a CT scan at Glan Clwyd Hospital, the purpose of which was to establish the effectiveness of treatment which he had been having for cancer of the oesophagus. On the 6th of May this was reported by a radiologist as incidentally revealing a clot on the lungs, a result which needed to be brought to the immediate attention of the referring clinician so that remedial treatment could be started. For reasons associated with working practices at that time the result of this scan was not acted upon until it was identified by Mr Reynold's GP on the 10th of May and he was immediately admitted to hospital where treatment was commenced. Despite appropriate treatment being undertaken over the course of the next few days, Mr Reynolds passed away at Glan Clwyd Hospital on the 15th of May 2021 with a subsequent examination establishing that he had died as a result of both the pulmonary emboli and a pneumonia. The evidence indicated that had treatment for the clot began sooner there would have been a better prospect of it being successful and further that the treatment for his cancer had been effective. On the balance of probabilities therefore it is likely that Mr Reynolds would not have died on the 15th of May 2021 if the result of his scan had been acted upon when reported by the radiologist on the 6th of May." The Cause of Death being recorded as 1(a) Pneumonia and Pulmonary Emboli due to Deep Vein Thrombosis 2.Emphysema of the Lung and Carcinoma of the Oesophagus (Treated)
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are as detailed in the narrative conclusion referred to above

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. – 1. Although it was identified quickly that existing working practices (whereby an irregular scan report had been placed on the desk of a clinician by a secretary and due to the absence of the clinician this report had not been seen and acted upon in a timely manner,) the health board did not fully implement a new Standard Operating Procedure, which was introduced to address this issue, until December 2021, seven months after the death of Mr Reynolds. 2. Furthermore an acknowledgement of the existence of the new SOP by Oncology and Haematology Secretaries was not completed until the 22nd of February 2022. 3. Finally at the time of the inquest, eleven days prior to the anniversary of Mr Reynolds' death the health board had not completed an audit process to ensure that the changes which had been introduced were being complied with and were therefore effective. 4. I am concerned that the length of time which it takes to implement changes and to ensure that new safe working practices are introduced and adopted by staff, results in the health board allowing known risks to patients to continue and therefore presents a risk to life.
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 by 1st of July 2022 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 Family of the Deceased 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 6th May 2022  Signature Senior Coroner for North Wales (East and Central)