REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Secretary of State for Health**
1	**CORONER** **Sarah Louise Slater,** Assistant Coroner for South Yorkshire (West)
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 (Investigatory) Regulations 2013. (1) Where – a. A senior coroner has been conducting an investigation under this Part into a person's death and b. Anything revealed by the investigation gives rise to concern that circumstances creating a risk or other deaths will occur, or will continue to exist, in the future, and c. In the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances, the coroner must report the matter to a person who the coroner believes may have the power to take such action. (2) A person to whom a senior coroner makes a report under this paragraph must give the senior coroner a written response to it. (3) A copy of a report under this paragraph, and of the response to it, must be sent to the Chief Coroner
3	**INVESTIGATION and INQUEST** On 22nd December 2016 I commenced an investigation into the death of Mr John Higgs. The investigation concluded at the end of the inquest on 7th April 2017. The conclusion of the inquest was that Mr Higgs died from 1(a) Ruptured Abdominal Aortic Aneurysm 2. Stroke, Frailty of old age A narrative conclusion was recorded as follows: Mr Higgs died in Barnsley General Hospital on the 18th November 2015 as a result of a ruptured abdominal aortic aneurysm.

	In March 2011, Mr Higgs attended Barnsley General Hospital and underwent a CT scan which identified the presence of a 6cm abdominal aortic aneurysm. This finding was not communicated to Mr Higgs despite him attending at the hospital on a number of occasions following the scan. In addition, the general practitioner was not informed therefore Mr Higgs was not referred to specialist vascular surgeons and he did not have the opportunity to consider any further treatment options prior to his sudden collapse in 2015.
4	**CIRCUMSTANCES OF THE DEATH** Mr Higgs attended Barnsley General Hospital on the 18th November 2015 following a fall and vacant episode. It was initially though that Mr Higgs had suffered a further stroke but an ultrasound scan revealed a 6.6cm abdominal aortic aneurysm which was leaking. He Higgs died later that same day. After Mr Higgs death, his wife received the death certificate and sent a letter to the hospital asking why she had not been informed that he husband had an aneurysm. This was investigated by the Trust and it was found that Mr Higgs had undergone a CT scan in March 2011 and the scan had identified the presence of a 6cm abdominal aortic aneurysm but the results had been overlooked at the time and therefore not communicated to Mr Higgs, other clinicians or his general practitioner. The evidence at the inquest was that presence of the abdominal aortic aneurysm was an unexpected finding on the CT scan. The report had been seen by the Consultant Surgeon in charge of the care, but he did not act upon these results because Mr Higgs was attending clinic 5 days later and therefore the Consultant would discuss them with the patient. At this time, the trust relied on paper records. Mr Higgs attended clinic and was seen by a junior doctor who either did not review the CT report or it was unavailable because it was still with the consultant awaiting filing on the patient records. There was no evidence in court of a safe system of communication at the time (2011). Mr Higgs attended at the hospital on a number of occasions after the scan results were available in 2011 and was seen by several different doctors but the CT scan results from 2011 were not looked at. In addition, the general practitioner was not informed therefore Mr Higgs was not referred to specialist vascular surgeons and he did not have the opportunity to consider any further treatment options prior to his sudden collapse in 2015.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving raise 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 **MATTER OF CONCERN** for the Secretary of State to consider is as follows: The inquest heard that the Trust now relies on an electronic system rather than the paper system as it did in 2011. However, any unexpected significant/serious radiological finding are still included in a report that is only sent to the Consultant in charge of the care and it is a matter for that doctor to notice that part of the report and to input this information on the system as a message. In essence, the procedures appear to be the same, it the mode of recording the information that had changed from paper to computer. No other measures have been put in place and the system is still reliant on

	one doctor noticing and recording the information. In addition, the Court heard there was no facility to place a "red flag" on the system to increase the likelihood of other clinicians being made aware of these unexpected and significant findings. The Trust has a radiology protocol for "unexpected cancer pathology" where the results are sent to the treating Consultant but also sent to the MDT Cancer Co-ordinator for action but no such protocol exists for non- cancerous but significant and potentially life threatening findings. The Secretary of State for Health is asked to consider whether it is appropriate for Trust to review its systems and procedures in place in relation to "unexpected (non-cancerous) radiological findings because HMAC [redacted] is concerned that this situation could occur again.
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 27th June 2017. 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: The family of Mr Higgs Chief Executive, Barnsley District General Hospital 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	**10th April 2017** ***Louise Slater*** Assistant Coroner South Yorkshire (West)