REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** The Glenfield Surgery. Mr J. Adler, Chief Executive, University Hospitals of Leicester NHS Trust. [redacted], Chief Operating Officer, East Leicestershire and Rutland Clinical Commissioning Group.
1	**CORONER** I am Lydia Brown Assistant Coroner, for the area of Leicester City and Leicestershire South
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 15 December 2016 I commenced an investigation into the death of Michael John Halfpenny. The Inquest concluded on 24th May 2016 Cause of death: 1a Multi-organ failure following emergency open repair for ruptured Abdominal Aortic Aneurysm. II. Ischaemic heart disease, Diabetes, Hypertension.
4	**CIRCUMSTANCES OF THE DEATH:** Mr Halfpenny requested his GP refer him for a screening ultrasound scan for aortic aneurysm during March 2016 due to a strong family history. The referral was sent to the radiological department at University Hospitals of Leicester but was rejected and no further action was taken. Had the referral been received by the vascular screening team they would have offered a scan and this would have confirmed a large aneurysm and surgical repair would have been planned to take place within 8 weeks. On 9th December 2016, Mr Halfpenny presented to his GP with severe abdominal pain and was appropriately referred by ambulance to the emergency department at UHL. On arrival he had to wait in the ambulance and then had a further wait in ED as the department was too busy to assess him. The diagnosis was only made when he was in peri-arrest some 3 hours after arrival and emergency surgery was then rapidly and appropriately arranged. On the balance of probabilities the outcome may have been different with earlier diagnosis and treatment.
5	**CORONER'S CONCERNS** Regarding the General Practice involvement - The referral should have been made directly to the vascular screening team but was made to the radiology department - No further action was taken when the screening request was refused

	- The court heard that screening has been in place in Leicester since the 1990's and nationally since 2013, and that the family saw posters advertising the service on display at Leicester Royal Infirmary but not at the GP surgery. - The GP practice were uncertain of the existing screening programme and on what criteria to refer patients Regarding the University Hospitals of Leicester NHS Trust - The referral request was marked by the radiology department that screening was "not offered" and the request was refused - The vascular team were unaware of the patient and the request and no system was in place to ensure any screening request would be directed to the correct department - The screening committee group set up by UHL were unaware of this matter and therefore had taken no action to ensure referrals were appropriately received and actioned.
I.	**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 Thursday 27th July 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; [redacted] (Daughter) 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	**[DATE** **1st June 2017** **[SIGNED BY CORONER]**