REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS	
	THIS REPORT IS BEING SENT TO: **Professor Sir Bruce Keogh** National Medical Director, NHS England, Skipton House, 80 London Road, SE1 6LH **The Royal College of General Practitioners** 30 Euston Square, London, NW1 2FB **The Society of Radiographers** 207 Providence Square, Mill Street, London, SE1 2EW
1.	**CORONER** I am Peter James Bedford, Senior Coroner, for the coroner area of Berkshire.
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 23rd November 2017 I conducted an Inquest into the death of Mrs Violet Levine Nelson of [redacted] who died at her home address on the 17th September 2016 aged 80 years. She collapsed suddenly at home and a post mortem examination revealed a cause of death of Ruptured Thoracic Aortic Aneurysm. A review of her medical history revealed that she had been diagnosed with an Aortic Abdominal Aneurysm on an ultrasound scan on the 22nd March 2012 at the Royal Berkshire Hospital in Reading. It was an incidental finding of the scan that Mrs Nelson had a 3.6cms suprarenal AAA. Mrs Nelson then had annual ultrasound reviews on the 22nd April 2013 that described a suprarenal AAA of 3.6cms and, again, on the 8th May 2014 when the report described an Infra-renal Aneurysm measuring 3.4cms. All of these ultrasounds were performed by a Sonographer at the Royal Berkshire Hospital in Reading. None contained any recommendations as to future care of Mrs Nelson.

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There were no further views of the progress of her Aneurysm until her collapse and death on the 17th September 2016.

As part of the evidence heard by me at the Inquest, I had a report from [redacted], Consultant Vascular Surgeon of Trinity College, Oxford.

4. **CIRCUMSTANCES OF THE DEATH**

Mrs Violet Nelson died in the circumstances clearly described in paragraph 3 of the report and the ultrasound reports provided in March 2012 and April 2013 were both completed and verified by a Sonographer. It is assumed that this Sonographer is by training a Radiographer and not a medically qualified Radiologist.

The Ultrasonography report of the 8th May 2014 was completed and verified by another Sonographer and again, presumed by training to be a Radiographer and not a medically qualified Radiologist.

The evidence from the expert, [redacted] included reference to the following matters:

1. It was his professional opinion that it was more likely than not that the Aneurysm identified on the abdominal Ultrasonography in March 2012 and believed to have been above the level of Mrs Nelson's renal arteries but within the abdominal cavity, was in fact the lower end of a large, clinically significant thoracic Aortic Aneurysm was likely to have had a maximum diameter greatly in excess of the small Supra-renal Aortic Aneurysm identified by the scan.

2. A specialist Vascular Surgeon would, in March 2012, have concluded that Mrs Nelson was suffering from a Thoracic Aortic Aneurysm and would have recommended that imaging of the Thoracic Aorta was required to determine the extent and maximum diameter of it. He would have expected this to have been achieved by CT examination.

3. He would have expected that any Consultant Radiologist identifying in 2012 the presence of a Supra-renal Abdominal Aortic Aneurysm on Ultrasonography of the abdomen, would have suggested in his report to the requesting Physician, that it would be appropriate to identify the diameter and extent of the Thoracic Aortic Aneurysm that was likely to be present.

4. [redacted] was of the belief that non-medically qualified Ultrasonographers do not have the necessary medical knowledge to allow them to make suggestions on referral or further investigations.

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5.	**CORONER'S CONCERNS** During the course of gathering evidence following this tragic death, evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless this action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – (1) If the reports of Ultrasonography in 2012, 2013 and 2014 had been overseen/verified by a Consultant Radiologist, it is likely that referral of Mrs Nelson to a Vascular Surgeon and CT examination of the chest would have prompted an appropriate response by the referring GP. (2) It is more likely than not that General Practitioners are not aware of the fact that the Ultrasonography finding of an Aneurysm of the Supra-renal Aorta is likely to indicate the presence of a larger Thoracic Aortic Aneurysm and that, in consequence, CT examination of the chest should be performed or the patient should be referred to a Vascular Surgeon. (3) Therefore, without an ultrasound report carrying an appropriate recommendation to the referring Clinician and if General Practitioners are not made aware of the fact the Ultrasonography finding of an Aneurysm of the Supra-renal Aorta is likely to indicate the presence of a large Thoracic Aortic Aneurysm requiring further investigation, similar deaths to that suffered by Mrs Nelson may occur in the future.
6.	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe your organisation has the power to take such action.
7.	**YOUR RESPONSE** You are under a duty to respond within 56 days from the date of this report, namely by **5th February 2018** 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.

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8.	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the family of [redacted] You are 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.	**7th December 2017** **Peter J. Bedford** **Senior Coroner for Berkshire**