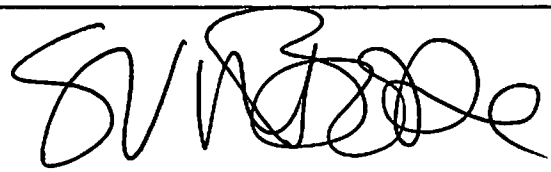
Coroner ME Hassell
HM Senior Coroner
Inner North London

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Simon Stevens** **Chief Executive NHS England** PO Box 16738, Redditch, B97 9PT
1	**CORONER** I am: Assistant Coroner Sarah Bourke Inner North London Poplar Coroner's Court 127 Poplar High Street London E14 0AE
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 1 September 2017, Assistant Coroner Buckett commenced an investigation into the death of William John Abrahams who was born on 18 May 1936. The investigation concluded at the end of the inquest, which was conducted by me on 17 January 2018. The conclusion of the inquest was that Mr Abrahams died of natural causes. I recorded a medical cause of death of: 1a ruptured abdominal aortic aneurysm

4	**CIRCUMSTANCES OF THE DEATH** Mr Abrahams presented to the A&E Department at the Royal London Hospital on 28 August 2017 with a 24-hour history of abdominal and back pain. He was found to have a ruptured abdominal aortic aneurysm. He underwent endovascular repair. The procedure was started under local anaesthetic with sedation but was then converted to general anaesthetic as Mr Abrahams' heart rate, blood pressure and clotting status was difficult to maintain. Mr Abrahams remained unstable during the procedure. He was found to have intraperitoneal fluid as a result of the rupture of the aneurysmal sac into the peritoneum. It was decided that Mr Abrahams would not survive any further intervention. He died at the hospital that evening at 6.48 pm.
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 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. – (1) Mr Abrahams was not invited for screening to check whether he had an Abdominal Aortic Aneurysm, as he was over 65 at the time that the screening programme was introduced. (2) Only about 20% of people that have a ruptured Abdominal Aortic Aneurysm survive (3) As Abdominal Aortic Aneurysms are asymptomatic until they begin to leak, the benefits of "opting in" to the screening programme may not be apparent to patients.
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 16 April 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the following: • HHJ Mark Lucraft QC, the Chief Coroner of England and Wales

	• [redacted] daughters of Mr Abrahams • I have also sent it to [redacted] who may find it of interest. 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	 **Sarah Bourke** **Assistant Coroner**