Coroner Service
West Sussex, Brighton & Hove

Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** The Chief Executive, University Hospitals Sussex NHS Foundation Trust
1	**CORONER** I am Joseph TURNER, Area Coroner for the coroner area of West Sussex, Brighton and Hove
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** An investigation under s.1 Coroners and Justice Act 2009 was commenced into the death of Paul Guy Robert Harries in September 2025, on receipt of an internal Patient Safety Incident Investigation report. (Following his death at his home address in Brighton on 9th October 2024, his family contacted the Patient Advice and Liaison Service and Complaints team on 28th February 2025 raising their concerns that Mr Harries had not been followed up appropriately following the diagnosis of an abdominal aortic aneurysm [AAA]). The inquest was formally opened on 25th September 2025. I concluded the inquest on 25th February 2026. Further time was afforded to the family and Hospital Trust to address me on the prevention of future deaths, without adducing or hearing any new evidence.
4	**CIRCUMSTANCES OF THE DEATH** In November 2020 Mr Harries had been diagnosed with an AAA through screening assessment under the National AAA Screening Programme. Following a scan on 12th November 2021 he was advised he would be referred to the Vascular team at the Royal Sussex County Hospital for additional scanning to obtain more accurate imaging. On 25th November 2021, due to the complexity of the AAA which extended into the iliac arteries, Mr Harries was referred to the Vascular Assessment Unit to take over the medical surveillance and scanning of his AAA. Following the referral to that Unit, a further scan in January 2022 measured an increase in the aneurysm. Mr Harries did not attend his next scan appointment on 19th July 2022. No further action appears to have been taken, and Mr Harries was then lost to follow up. He attended the Emergency Department in February 2023, after a week of coughing up blood; a scan incidentally showed a further increase in the aneurysm, but this was not highlighted to the GP and not included in the discharge summary. The GP

	then saw Mr Harries due to high blood pressure in April 2024 and first became aware of the recent history and results and referred Mr Harries as 'urgent' to the Vascular Surgery team. The vascular surgeon operated a different priority system and rated Mr Harries as 'amber' which meant a triage within 6 weeks and then to be seen within c.40 weeks. A CT scan on 2nd May 2024 showed the AAA but it was 'difficult to measure' and an outpatient appointment was then booked on 13th September 2024 for 19th October 2024. However, Mr Harries sadly died from a ruptured AAA before and whilst awaiting that appointment. Among the issues at the inquest were what actions should have been taken following the missed VAU scan on 19th July 2022 to prevent the patient being lost to follow up, and the sequence of events following the urgent request for review from the GP, including the 'recategorising' of urgency and then long wait for an outpatient appointment, as well as how the incidental scan findings were not alerted to the GP.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. The rationale for this particular report is that, as paragraph 42 of Chapter 16 of the Chief Coroner's Guidance for Coroners on the Bench advises - 'where steps have been taken but remain inadequate or incomplete a PFD report may still be required'. I also bear in mind that PFD reports are not just required where I perceive the need to prevent recurrence (which I accept may be practically impossible) but to reduce the risk of death. The report is written within that ambit. In those circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) Although I accept that a system of audits is now under way, these are evidently retrospective and the changes made do not appear to fully resolve the observed weaknesses and risk of differences apparent in the inquest within the GP-Consultant surgeon-Careflow booking chain whereby the urgency expressed by the GP does not successfully translate into an urgent booking, because there remains the risk of manual coding error and/or that there is no express reason given or reported back to the GP as to why their patient is or will be afforded the proposed urgency. Again, although there is current and considerable planned progress on integration of IT systems, this work is not yet complete and referrals remain reliant on 3 separate systems which are not yet fully joined up. Incidental findings from tests conducted in the ED are not always reported

	to the GP where these may not relate to the presenting complaint. ED policy appears to remain inconsistent. This is especially important as it means a Patient with a significant condition, for which they are under their GP, may have a change in that condition identified at the ED which is not then always reported back or highlighted urgently to the GP.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) 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 June 15, 2026. 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: Those members of Mr Harries' family identified and who participated in the inquest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. The Chief Coroner may publish either or both in a complete or redacted or summary form. They may send a copy of this report to any person who they believe 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: 20/04/2026 [redacted] Joseph TURNER Area Coroner for West Sussex, Brighton and Hove