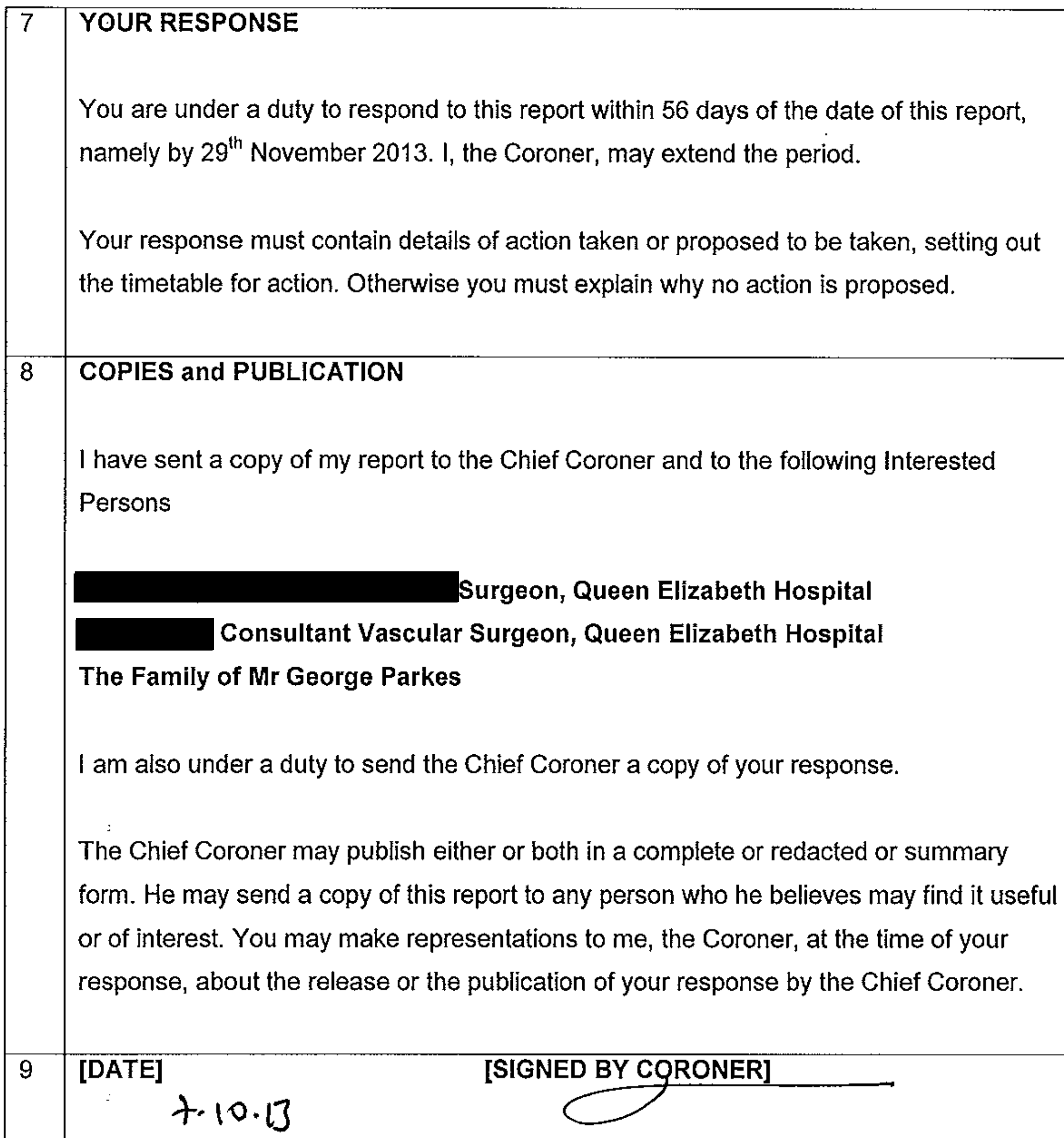
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] Chief Executive, University Hospitals Birmingham NHS Foundation Trust**
1	**CORONER** I am Sarah Elaine Ormond-Walshe, Acting Senior Coroner for the coroner area of Birmingham and Solihull.
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 4th January 2013 I commenced an investigation into the death of George Leonard Parkes, age 84. The investigation concluded at the end of the inquest on 4th October 2013. The conclusion of the inquest was: **Medical cause of death** 1a. **RUPTURED ABDOMINAL AORTIC ANEURYSM** **Conclusion of the Assistant Coroner as to the death** Died during surgery being carried out for a ruptured abdominal aortic aneurysm.
4	**CIRCUMSTANCES OF THE DEATH** Please see attached.

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 will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – I attach the summing up in relation to this case which essentially involves the situation where a patient with an abdominal aortic aneurysm was "lost to follow up". The consequences were that it meant that his aneurysm became so big that it ruptured and he died. Potentially, this was a preventable death as if he was eligible, he would have been given the opportunity of having fenestrated endovascular repair which probably would have meant he would not have died when he did. It has been suggested to me by the witnesses that having a specialist nurse clinic (enabling open monitoring of patients with abdominal aortic aneurysms) and dedicated procedure database/register, would prevent this situation happening again. The guidance from the Chief Coroner is that in writing these Reports, the Coroner does not make a very specific recommendation and I do not in this case. I do, however, support the Consultant Vascular Surgeons at the Queen Elizabeth Hospital (specifically [redacted]), in actions such as the nurse clinic being set up, to prevent future loss of life, and any other measure(s) which will prevent future "lost to follow-up" situations.
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 29th November 2013. 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 **Surgeon, Queen Elizabeth Hospital** **Consultant Vascular Surgeon, Queen Elizabeth Hospital** **The Family of Mr George Parkes** 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]** 7.10.13 **[SIGNED BY CORONER]**

CASE NUMBER: 0029/2013

IN MAJESTY'S CORONER'S COURT
JURISDICTION – BIRMINGHAM AND SOLIHULL

20th August 2013
and
4th October 2013

The Coroner's Court
50 Newton Street, Birmingham, B4 6NE

Inquest touching the death of

GEORGE LEONARD PARKES

Mr. Parkes died suffering a ruptured abdominal aortic aneurysm.

Witnesses

I have heard from Dr J Singh a Surgical Registrar who was looking after Mr Parkes on the day he came into the Queen Elizabeth Hospital on 2 January 2013 with a Ruptured Abdominal Aortic Aneurysm. I have heard from Mr R K Vohra and Mr M Simms both Consultant Vascular Surgeons at the Queen Elizabeth Hospital Mr Parkes having been under Mr Simms at all material times and Mr Vohra being the Surgeon involved in the matters and the surgery on 2 January 2013 when essentially the surgery had to be abandoned part way through because it was clearly going to be futile and would not save Mr Parkes' life.

Chronology

For me, things start on or about the 2 June 2009 when it was picked up that Mr Parkes had a 9cm Abdominal Aortic Aneurysm. I have heard that it is common place for people then to be assessed to see whether they are eligible for Endovascular Repair rather than Open Repair. Clearly Mr Parkes did fit that criteria because he underwent an Endovascular Repair of the Abdominal Aortic Aneurysm on 9 June 2009 and this would have been carried out by a qualified Technician and a stent was put in. I have heard, historically, in the past, it was thought that patients would not necessarily need follow-up after a couple of years. However, at all material times and in the current day the medical research is that patients do require follow-up, I was told, in all the evidence, that six months follow-up is the correct time, but in the Information for patients and carers book called *"Recovery from Endovascular Surgery for Abdominal Aortic Aneurysm Repair"* this follow-up to be scanned at 6 weeks then 6 months and then every year.

At about 6 weeks post repair, correctly, Mr Parkes underwent a CT Scan on 29 July 2009. This was routine and satisfactory. On 16 September 2009 he was seen in clinic having been referred from his GP with a problem with varicose veins and a left foot swelling. In that regard he was seen for the aneurysm as well and had a CT Scan and the aneurysm was showing signs of shrinkage.

On 20 January 2010 he was seen in Clinic for treatment of the varicose veins and again had an ultrasound which showed shrinkage of the aneurysm.

On 26 February 2010 he had his varicose veins injected as a day case and then in his follow-up, to do with his varicose veins, on 19 April 2010 in Clinic again, he had an ultrasound and it did show the fact that the aneurysm had shrunk. I have heard that it was common for the investigations to drop down to an ultrasound from a CT Scan to avoid risk from the radiological point of view at the time and that has remained the case since - the Ultrasound Scan being a less invasive investigation involving some jelly on skin and a scanner.

It is from the 14 June 2010 where, after that clinic appointment to do with a blockage in his knee, from the vascular point of view, he did have a duplex scan but not of the aorta. Although he was seen by Mr Simms, who then ordered the Scan, after the scan he was then seen in the Clinic by a Junior Doctor who popped his head round to Mr Simms in Mr Simms' room to ask him if it was OK to discharge Mr Parkes as the scan was OK. The answer was yes. This was a failure. He should not have been discharged.

I have heard evidence, essentially through Mr Parkes' son, that Mr Parkes would not have been a gentleman to miss any appointments had they been sent to him and indeed he did not miss any appointments that were offered to him. We do know he was not followed up from the 14 June 2010 to 2 January 2013 in relation to this Aortic Aneurysm. I have heard the evidence that as soon as a patient has the pain and feels faint it is very likely that the aneurysm

has ruptured and both Consultants agree with each other that Mr Parkes' aneurysm had ruptured before he had come into Hospital although he did stay cardio vascularly stable, by the sound of it, throughout the time in Accident and Emergency.

Mr Parkes after had a big haematoma when he came in which was a sign of rupture too and he had periods of low blood pressure.

Mr Parkes had been recently out on his bicycle and he had been on a bus on 2 January 2013 and was an active gentleman. However, with the benefit of hindsight the Family can see that there were times when he was distracted and breathless particularly after climbing stairs for instance.

Timing of events on 2nd January 2013

Due to the fact that Mr Parkes' Son was asking some questions about the timing of things, I say the following: The timing of matters on that day appears to be that Mr Parkes came into Casualty at 16.50 hours and his Notes were written up by the Doctor at 17.17 hours and the induction of the anaesthetic started at 21.34 hours. There is no record of the time that the CT Scan was done between 17.17 and 21.34 and Mr Simms is not critical of there being any delay or not suggesting there is any delay because Mr Parkes was stable. However, my understanding of his evidence is that with a 12 cm aneurysm on scan (and 13 to 14 cm aneurysm eyeballing the aneurysm in theatre) this is phenomenally difficult to treat at this stage anyway. This was also an aneurysm that was high up.

Mr Parkes had collapsed at his Brother's home and the Family's evidence is that the CT Scan was not done until about 20.30 hours and that their understanding was there was some discussion about whether his blood pressure lying and standing was different and Mr Parkes in general was well the day before he came into hospital on 2 January 2013.

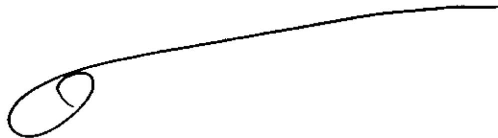
Causation

I have asked the Consultants separately about causation in relation to the "lost to follow-up" issue. Mr Vohra's evidence is that with an open repair there would have been a 70% mortality but at the time there was available, (although not at the Queen Elizabeth, at Heartlands, for instance), a procedure called a fenestrated endovascular repair (which has been available for the last 7 to 8 years in Specialist Centres) would have been discussed with Mr Parkes, and whether he wished to undergo that, and if so he would have been referred probably to Heartlands Hospital. The eligibility criteria for having Endovascular Repair used to be that 40% got through and now it is almost 75%. The literature says normally there would be a 1 to 2% mortality with it but Mr Vohra's evidence is that Mr Parkes' mortality would be 10%. I am, however, adopting some of Mr Simms' evidence therein to Mr Vohra's evidence as Mr Simms has explained a little bit more about the fact that the Queen Elizabeth refer patients for that specialist procedure. Mr Simms would put Mr Parkes as having a higher mortality than 10% - he would have said getting towards 20%.

A plan would be, after the CT Scan to have regular ultrasounds done with a lateral plain abdominal x-ray (the lateral plain abdominal x-ray to see if the stent had moved down).

From the causation point of view, had Mr. Parkes not been discharged, he would on the balance of probabilities, if eligible (and I find on the balance of probabilities, he would have been eligible), and accepted fenestrated endovascular repair, he would not have died on 2nd January 2013.

At the time that there was this period where Mr Parkes was "lost to follow up", the Trust was going through a transitional phase of partly transferring into a paperless system. This started in about 2009. I am told today that it is paperless and that it is easier for Doctors to read the history of patients in the new computerised system.



Miss Sarah Ormond-Walshe
Acting Senior Coroner
Birmingham & Solihull Districts