Tony Williams
Senior Coroner for Somerset

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Medical Director, Yeovil District Hospital, Yeovil, Somerset and [redacted] GP, Bute House Surgery, Sherborne, Dorset**
1	**CORONER** I am Tony Williams, Senior Coroner for Somerset
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 27/04/2016 I commenced an investigation into the death of Christina Ingrid Smith, 70 . The investigation concluded at the end of the inquest on 15/02/2017. The conclusion of the inquest was Natural Causes On 31st March 2016 at [redacted] Sherborne Mrs Smith died from a naturally occurring haemorrhage. Intrathoracic Haemorrhage Ruptured Dissecting Aortic Aneurysm - Chronic Pulmonary Obstructive Disease
4	**CIRCUMSTANCES OF THE DEATH** On 30th March 2016 Mrs Smith was referred by her GP to the Emergency Department (ED) of Yeovil District Hospital (YDH). Those assessing Mrs Smith in the ED were not aware of her being under review for a known Abdominal Aneurysm (AA). An ultrasound scan was requested to determine if Mrs Smith had a gallbladder disease. On 30th March 2016 Mrs Smith returned to YDH when the scan was performed and the results received. By this time those assessing Mrs Smith knew of the AA and were satisfied it had not changed in size. A CT scan was requested. The CT scan was planned for 1st April 2016. Overnight Mrs Smith deteriorated and died at home. Post Mortem confirmed the cause of death as set out above.
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. – (1) A report on Mrs Smith of 2011 identified both an Abdominal Aneurysm and a Thoracic Aneurysm. It appears Mrs Smith was never told of the existence of the Thoracic Aneurysm. It appears Mrs Smith's GP was never told of the existence of the Thoracic Aneurysm. (2) Only Mrs Smith's Abdominal Aneurysm was placed under surveillance so as to monitor any possible increase in size. Mrs Smith's Thoracic Aneurysm was not placed under surveillance. (3) There appears to have been a breakdown in communication with regard to advising both Mrs Smith and her GP as to the existence of the Thoracic Aneurysm.

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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 30/05.2017. 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] 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	Dated 04 April 2017 Signature_____ Senior Coroner for Somerset

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