REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT DATED 21 April 2017 IS BEING SENT TO:** [redacted] **Interim Chief Executive, Cardiff and Vale University Health Board**
1	**CORONER** I am Philip Charles SPINNEY, Area Coroner, for the coroner area of South Wales Central.
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 25 January 2017 I commenced an investigation into the death of **David Thomas Evans.** The investigation concluded at the end of the inquest on the 20 April 2017. The conclusion of the inquest was a narrative conclusion as follows: *David Thomas Evans died as a result of complications following a ruptured thoraco-abdominal aneurysm.*
4	**CIRCUMSTANCES OF THE DEATH** On 15 January 2017 David Thomas Evans presented at University Hospital Wales Emergency Department with severe abdominal pain. Whilst in hospital he underwent an ultrasound scan of the abdominal aorta that revealed a diameter of 40mm, no further investigation of the aorta was conducted and he was discharged with a diagnosis of diverticulitis and given antibiotics. His abdominal pain persisted and on 22 January 2017 he was admitted to University Hospital Wales. An examination revealed a ruptured aortic aneurysm. Mr Evans underwent emergency surgery that revealed a significant amount of ischaemic bowel from which he was unable to survive. He sadly died later that day.
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) The evidence revealed that the Dr that conducted the Focussed Assessment with Sonography for Trauma (FAST) Ultrasound examination had not completed the necessary training and should have conducted the scan under supervision. (2) The evidence revealed that records of FAST ultrasound examinations are not

	routinely stored preventing evaluation of scans to be undertaken after the event. (3) The evidence revealed that where an Abdominal Aortic Aneurysm (AAA) is identified in the emergency department by a FAST ultrasound examination and a patient is symptomatic there should always be an appropriate escalation of care.
6	**ACTION SHOULD BE TAKEN** **(1) Consideration should be given to reviewing your procedures related to the training and the supervision of those undergoing training in conducting FAST Ultrasound examinations.** **(2) Consideration should be given to reviewing your procedures for recording the outcome of FAST ultrasound examinations.** **(3) Consideration should be given to reviewing your procedures surrounding the management of symptomatic patients where an AAA has been identified by a FAST ultrasound examination.** In my opinion action should be taken to prevent future deaths and I believe you and 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 **16 June 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 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	**SIGNED:** **Mr Philip Spinney** **HM Area Coroner**