for Plymouth Torbay and South Devon

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Dr Philip Hughes, Medical Director, Derriford Hospital Trust**
1	**CORONER** **Ian Michael Arrow, Senior Coroner for Plymouth, Torbay and South Devon**
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** **Following an Inquest opened on 10 December 2018 and an Inquest Hearing on 22 August 2019 the following was found:** **Name of the deceased:** **Euan David Brinley ELLIS** **Medical Cause of death:** **1a) Haemopericardium** **b) Ruptured Aneurysm of Ascending Thoracic Aorta** **c) Marfan's Syndrome**
4	**CIRCUMSTANCES OF THE DEATH** The deceased, together with his close and extended family, live with Marfan's Syndrome. He therefore had a cardiac vulnerability. He had missed a number of scheduled cardiac appointments. He was admitted to an Emergency Department with a history of chest pains on 19 November 2017. A clinical decision was made not to carry out further tests but to refer him to a primary carer, namely his General Practitioner, for a future appointment. It appears the Emergency Department had limited access to the deceased's Health Records. On the balance of probability the clinical decision maker would have been better informed had the decision maker had such access to all Medical Records. The deceased attended his General Practitioner on 20 November 2017. That Doctor referred the deceased for a non urgent Echocardiogram. That Doctor appeared to have limited information about the deceased's cardiac vulnerability. The deceased suffered a fatal Haemopericardium at home on 23 November 2017.
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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] At the Inquest the Coroner received evidence from [redacted] who referred to a multi disciplinary investigation which contained recommendations. The Coroner is concerned to be assured that the recommendations are being followed.

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. I request that you review the steps taken to put in place the recommendations referred to by [redacted] which, for ease of reference, are attached to the letter accompanying this Report. Kindly report the steps taken so far. Kindly provide an update in six month's time as to the expected completion date of the recommendations.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by Enter date of response . 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] and the Local Safeguarding Board (where the deceased was under 18)]. I have also sent it to who may find it useful or 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	Dated 22 August 2019 Signature