East London Coroners

MISS N PERSAUD
SENIOR CORONER

Walthamstow Coroner's Court, Queens Road, Walthamstow, E17 8QP
Telephone 020 8496 5000 Email coroners@walthamforest.gov.uk

REF: 110253

21st October 2020

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **[redacted], Public Health England, Wellington House, 133-155 Waterloo Road, London, SE1 8UG – [redacted]@nhs.net** 2. **Mr [redacted], Chief Executive, The Barking Havering and Redbridge University NHS Trust, Queen's Hospital, Rom Valley Way, Romford, Essex, RM7 0AG – [redacted]@nhs.net**
1	**CORONER** I am Mr Graeme Irvine Area Coroner for **East London**
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 18 February 2019, this court commenced an investigation into the death of Roger Wood. The investigation concluded at the end of the inquest on 14th October 2020. I made a determination of a narrative conclusion in which I concluded that Mr Wood's death was as a result of natural causes, contributed to by a lack of care. The medical cause of death was: 1a Ruptured Abdominal Aortic Aneurysm
4	CIRCUMSTANCES OF THE DEATH Mr Roger William Wood was diagnosed as suffering from an Abdominal Aortic Aneurysm ("AAA") and since 2005 had been subject to surveillance to monitor that condition. On 5th June 2017 Mr Wood underwent an ultrasound scan that measured the AAA to be 5.5 cms in AP diameter. The measurement was significant, the AAA had grown to a size where the risks presented by the condition outweighed the risk of treatment, accordingly at this point, Mr Wood ought to have been referred for treatment. In 2017 the local procedure in cases of this type was for imaging reports to be sent to the patient's GP, and for the GP to refer the matter to a vascular surgery specialist.

A report of the scan was sent to Mr Wood's GP, Dr by the hospital sonographer utilising an electronic reporting system Cyberlab.

The scan was received by Dr 's surgery, but not acted upon. Mr Wood was not referred to a specialist.

The following year, the annual scan measured the AAA to be 5.96 cms in diameter. This time, the results were properly assessed by the GP and a referral was made to vascular surgeons.

The referral led to a plan to treat the AAA with an "EVAR" stent. Regrettably, Mr Wood could not undertake this treatment as before the appointed date he sustained a fatal rupture to the AAA on 12/2/19.

Expert evidence heard by this court confirmed that had a similar treatment plan been commenced in 2017, it is likely that Mr Wood would have been protected from a future AAA rupture for life.

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.

The ultrasound scan of Mr Wood's AAA completed in June 2017 measured the aneurysm as 5.5 cms. The report simply stated the size and position of the AAA.

Expert evidence heard by this court confirmed that the nationally accepted, established threshold for intervention in AAAs was when an aneurysm measured 5.5cms (or greater).

In 2017, the policy in place was for AAA ultrasound scan results to be sent to the patient's GP for assessment. The GP was to decide whether to refer the patient on for treatment.

In Mr Wood's case, the GP either overlooked the results or considered them and determined that the size of the AAA did not require follow-up treatment. In either scenario, vital diagnostic information was not acted upon with a fatal result.

In the light of the sad facts of Mr Wood's death, Barking, Havering and Redbridge University NHS Trust have now changed Trust policy. Now when a patient is identified to have a AAA equal or greater than 5.5cm results include advice to make a vascular referral are not simply sent to a GP electronically, they are also emailed. This change undoubtedly improves matters, but does not entirely eliminate the risk of these tragic circumstances being repeated by directly triggering a referral.

My concern is that the current treatment pathway contains a possibly redundant link, the role of the GP. A link, which as demonstrated in Mr Wood's case, is capable of failure.

6

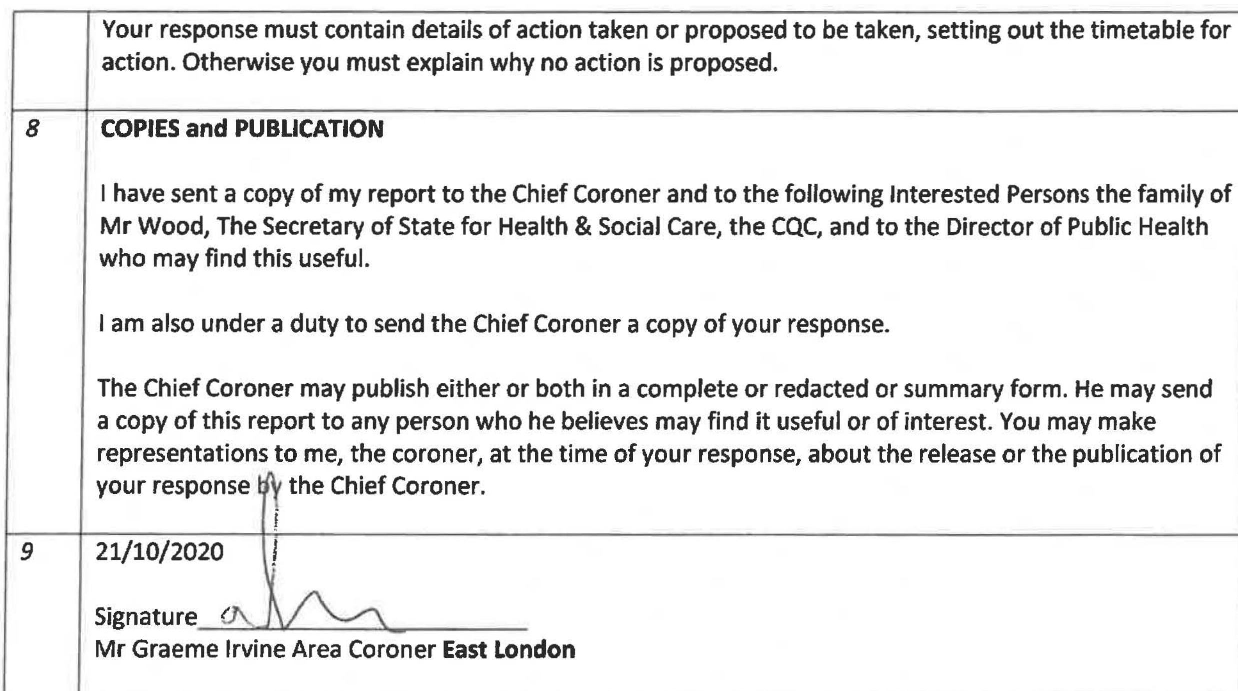
ACTION SHOULD BE TAKEN

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 **17th December 2020.** 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 the family of Mr Wood, The Secretary of State for Health & Social Care, the CQC, and to the Director of Public Health who may find this useful. 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	21/10/2020 Signature Mr Graeme Irvine Area Coroner **East London**

East London Coroners

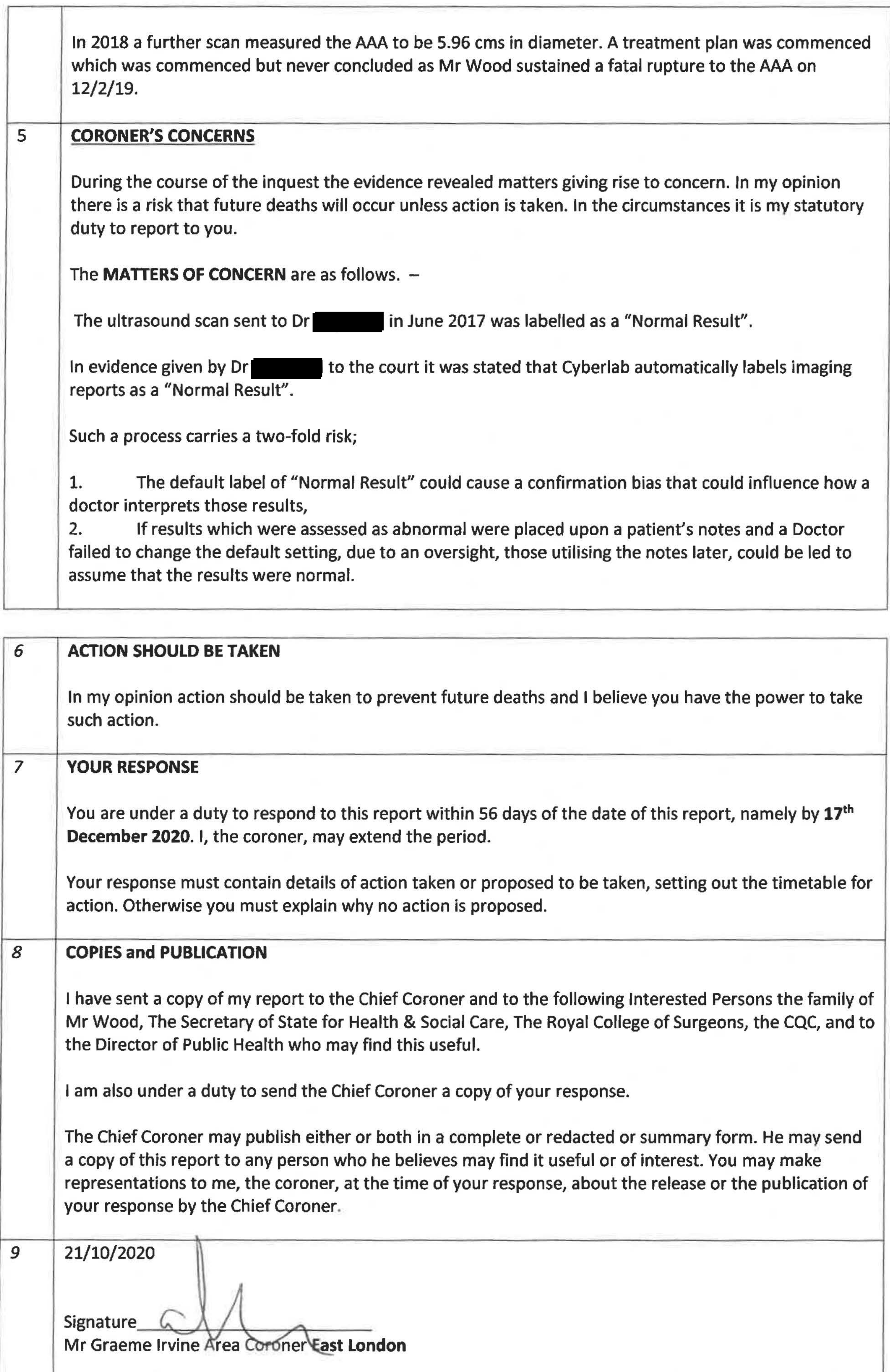
MISS N PERSAUD
SENIOR CORONER

Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
Telephone 020 8496 5000 Email coroners@walthamforest.gov.uk

REF: 110253

21st October 2020

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Chief Executive, Clinisys UK, Culverdon House, Abbots Way, Chertsey, Surrey, KT16 9LE – [redacted]@clinisys.co.uk** **2. Dr [redacted], Maylands Health Care, 300 Upper Rainham Rd, Hornchurch, RM12 4EQ - [redacted]@nhs.net** **3. Mr [redacted], Chief Executive, The Barking Havering and Redbridge University NHS Trust, Queen's Hospital, Rom Valley Way, Romford, Essex, RM7 0AG – [redacted]@nhs.net**
1	**CORONER** I am Mr Graeme Irvine Area Coroner for **East London**
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 18 February 2019, this court commenced an investigation into the death of Roger Wood. The investigation concluded at the end of the inquest on 14th October 2020. I made a determination of a narrative conclusion in which I concluded that Mr Wood's death was as a result of natural causes, contributed to by a lack of care. The medical cause of death was: 1a Ruptured Abdominal Aortic Aneurysm
4	**CIRCUMSTANCES OF THE DEATH** Mr Roger William Wood was diagnosed as suffering from an Abdominal Aortic Aneurysm ("AAA") and since 2005 had been subject to annual surveillance to monitor that condition. On 5th June 2017 Mr Wood underwent an ultrasound scan that measured the AAA to be 5.5 cms in AP diameter. The diameter measured is significant, it indicated that AA had reached a size where treatment was indicated. At this point Mr Wood ought to have been referred for a stenting procedure. A report of the scan was sent to Mr Wood's General Practitioner, Dr [redacted] by the hospital sonographer utilising an electronic reporting system Cyberlab.



	In 2018 a further scan measured the AAA to be 5.96 cms in diameter. A treatment plan was commenced which was commenced but never concluded as Mr Wood sustained a fatal rupture to the AAA on 12/2/19.
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. – The ultrasound scan sent to Dr in June 2017 was labelled as a "Normal Result". In evidence given by Dr to the court it was stated that Cyberlab automatically labels imaging reports as a "Normal Result". Such a process carries a two-fold risk; 1. The default label of "Normal Result" could cause a confirmation bias that could influence how a doctor interprets those results, 2. If results which were assessed as abnormal were placed upon a patient's notes and a Doctor failed to change the default setting, due to an oversight, those utilising the notes later, could be led to assume that the results were normal.

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 **17th December 2020.** 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 the family of Mr Wood, The Secretary of State for Health & Social Care, The Royal College of Surgeons, the CQC, and to the Director of Public Health who may find this useful. 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	21/10/2020 Signature________________ Mr Graeme Irvine Area Coroner **East London**