Barts Health
NHS Trust

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Chief Medical Officer
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PRIVATE & CONFIDENTIAL

Ms Nadia Persaud
HM Senior Coroner

Dear Ms Persaud

RE: Regulation 28: Report to Prevent Future Deaths

I write in response to the recent Regulation 28: Report to Prevent Future Deaths notice regarding the care of Michael Robert Collins. First, thank you very much for granting us an extension to provide a response, in recognition of the pressures brought by the second COVID surge.

Michael Collins was referred by his GP to the respiratory team on 06/12/2016, after a chest x-ray report suggested a computed tomography (CT) scan should be performed for better evaluation of the chest. Referral triaged by the respiratory team on 13/12/16 and a CT scan was requested.
The CT scan was performed and reported in January 2017, diagnosing an ascending thoracic aortic dilatation, supra-renal aortic dilatation and an infra-renal aortic aneurysm.

The findings within this report were not acted upon by the requesting team until Mr Collins was seen in clinic in August 2017, when his GP was informed. Mr Collins was referred by his GP to the vascular service in September 2017. There were delays to his appointment process due to human error and he was eventually seen in the vascular clinic in February 2018.

Following discussion in the combined aorto-vascular MDT on 14/03/18, Mr Collins was referred to a different vascular team. On 06/04/18, at 14:00hs, a CT of the abdomen (CTA) was performed showing an aneurysm of 7.0 cm with no leak or rupture. On the way home from the hospital appointment Mr Collins had a cardiac arrest and was brought to the Emergency Department at RLH around 17:00 but sadly died..

The matters of concern raised in the Regulation 28 notice were:

1. The inquest heard that the CERNER system does not always ensure that results are sent to the requesting clinician, and that results are sometimes sent to doctors who have no involvement in the patient's care.
2. The inquest heard that radiologists can drop reports into a folder which contains unexpected and significant findings, but it is not easily apparent to the reporting radiologist that the report has reached the appropriate clinician.

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Regarding the first matter of concern
The respiratory team have developed a Standard Operating Procedure to ensure that all investigation results are reviewed promptly, including when the person who requested the investigation is not at work.

Regarding the second matter of concern
The trust Divisional Director for Imaging has reviewed the processes used to notify unexpected and significant findings in consultation with the Clinical Director for Imaging at Whipps Cross. The system has been improved and is now formally incorporated within the trust Standard Operating Procedure.

Thank you for communicating your concerns to us - we believe that our hospital is safer as a result of the action we have taken to address them.

Yours sincerely

[redacted]

Chief Medical Officer
Barts Health NHS Trust

CC: