East London Coroners
MISS N PERSAUD
HM SENIOR CORONER
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
Telephone 020 8496 5000 Email [redacted]

REF: [redacted]

30 October 2020

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] Chief Executive, Barts Health, Royal London Hospital, Whitechapel Road, Whitechapel, London, E1 1BB
1	**CORONER** I am Nadia Persaud Senior 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 the 16th October 2019 I commenced an investigation into the death of Michael Robert Collins. The investigation concluded at the end of the Inquest on the 22nd October 2020. The conclusion of the Inquest was a conclusion of natural causes.
4	**CIRCUMSTANCES OF THE DEATH** In November 2016 Mr Collins presented to his GP with shortness of breath. He underwent a chest xray which revealed abnormalities. He was referred to the chest clinic and underwent a chest CT scan on 17 January 2017. The CT scan of January 2017 revealed an abdominal aortic aneurysm of 4.9cm. The finding of the abdominal aortic aneurysm was not highlighted to the referring team by the radiologist. Mr Collins was seen in the chest clinic on 2 February 2017. The CT scan was noted by the respiratory consultant, but she took no steps to request a referral to the vascular surgeons. No letter was sent to the GP to report the findings at clinic or findings of the CT scan. Whilst the 4.9cm aneurysm would not have required surgical intervention, it would have required ongoing monitoring. On the 2 August 2017 Mr Collins was seen by the respiratory physician who wrote an "urgent" letter to the GP requesting that the GP make a referral to the vascular team. The letter was dictated on the 14 August 2017 and received in the GP surgery on 22 August 2017. The respiratory physician could have made a direct referral to the vascular team, in light of the delay in acting on the January 2017 scan report. This was not done. The GP made a referral to the vascular team on the 7 September 2017. The referral was erroneously directed by the receiving vascular surgeon to the cardiothoracic team. Mr Collins should have been seen by a vascular surgeon within 8 weeks (by the 7 November 2017). Instead, he was seen by a cardio-thoracic

	surgeon on the 26 February 2018. A further CT scan was directed and review by the vascular surgeon was requested on 14 March 2018. Mr Collins attended the CT scan on the 6 April 2018. The CT scan showed an abdominal aortic aneurysm of 7cm. Mr Collins very sadly passed away at Whipps Cross Hospital, following the scan on the 6 April 2018. He died as a result of a ruptured abdominal aortic aneurysm. The evidence revealed that surgical intervention was not indicated for Mr Collins in light of his co-morbidities. No other action could have been taken to avoid the risk of rupture. Mr Collins' death could not therefore have been avoided.
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 Inquest heard evidence that the current CERNER system does not always ensure that results are sent through to the referring clinician. The Inquest heard evidence of a "quirk" in the system whereby results will be sent through to doctors who have no involvement in the patient's care. 2. The Inquest heard evidence that radiologists can now drop reports into a folder where there are unexpected and significant radiological findings. There is a specific folder relating to the finding of abdominal aortic aneurysms. The radiologist however raised a concern at the Inquest that it is not easily apparent to the reporting radiologist that the report has reached the appropriate clinician.

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 b **25 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 family (children of the deceased), and to the CQC and Director of Public Health. 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	30/10/2020 Signature Ms Nadia Persaud Senior Coroner **East London**