REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **RE: William Walton Jackson Deceased** **THIS REPORT IS BEING SENT TO:** **1. Sir Leonard R.Fenwick.CBE. Chief Executive of Newcastle Foundation NHS Trust**
1	**CORONER** I am D.LI. Roberts, Senior Coroner, for the coroner area of North & West Cumbria
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 2.12.2013 I commenced an investigation into the death of William Walter Jackson Aged 78. The investigation concluded at the end of the inquest on 6.11.14 The conclusion of the inquest was 1a) Haemothorax b) Ruptural descending thoracic aortic aneurysm. Conclusion: Natural Causes
4	**CIRCUMSTANCES OF THE DEATH** In the spring of 2013 the deceased was diagnosed with severe aortic regurgitation, a large ascending aortic aneurysm and severely impaired left ventricular function. His descending aorta was also aneurysmal. In the 26th June 2013 he underwent an operation at the Freeman Hospital to replace the aortic valve and the ascending aorta. The plan was to review the descending aorta in Spring 2014. By the Bank Holiday Monday of the 26th August 2013 he had become unwell. At the Cumberland Infirmary on the 27th August a CT Scan of his aorta was performed. This scan revealed there was haemorrhage in the descending aorta. The reporting radiologist did not perceive the increase in thickness of the aortic wall and intramural haematoma evidencing, at last stage, a contained rupture. This lack of appreciation of acute aortic pathology resulted in an inaccurate report which was relied on by subsequent clinicians. He left the hospital on the 27th but was admitted as an inpatient on the 30th August and died on the 4th September 2013. The true nature of his presenting problem was not diagnosed by his treating clinicians, but had it been, on the balance of probability it is unlikely that anything other than conservative treatment would have been proposed.

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 CIC records showed that an A&E doctor had spoken to a Specialist Cardio Thoracic Registrar at the Freeman Hospital. Inquiries of the Freeman showed that there was no record/recollection of this contact. (2) I understand there is no system at the Freeman to formally record sudden interactions. This means no traceable record and no means by which the Freeman doctor could be identified let alone recall the advice given. (3) The advice appears to have been given without the Freeman doctor actually seeing the CT Scan. Has the images been reviewed it is possible that the true state of the deceased's health would have been ascertained. (4) Independent of the issue of an enquiry being able to establish what advice was given at the time; there is a risk that the way such advice appears to have been given could place patients lives at risk.
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 20th January 2015 hence. 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. 1. [redacted] 2. [redacted] – Scott Duff & Co. Solicitors 3. Mrs Ann Farrar – Chief Executive NCUH NHS Trust 4. [redacted], Beachcroft Solicitors I am also under a duty to send the Chief Coroner a copy of your response. Also to [redacted] 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.
	24.11.14 **D.LI. HM Senior Coroner**