REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **1. [redacted] – A&E Consultant and Lead with the Isle of Wight Ambulance Service** **2. [redacted] – Clinical Risk and Claims Manager, Isle of Wight NHS Trust**
1	**CORONER** I am Caroline Sarah Sumeray, Senior Coroner for the Coroner Area of the Isle of Wight.
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 20th June 2013 I commenced an investigation into the death of Lara Mamula, aged 42. The investigation concluded at the end of the inquest on 13th November 2014. The conclusion of the inquest was Natural Causes Contributed to by Neglect. The medical cause of death was found to be: 1a Heart Tamponade 1b Ruptured Dissecting Aortic Root Aneurysm 1c Loeys-Dietz Syndrome
4	**CIRCUMSTANCES OF THE DEATH** 1) Lara Mamula was born on 1st July 1970. At the time of her death, she was 42 years of age. 2) On 11th May 2011 she presented with chest pain and tachycardia which was treated as an emergency and she was found to have a Debakey type III aortic dissection. She was kept under review until it was discovered that her aneurysm had progressed and she then had planned surgery to repair her aneurysm on 22nd February 2012 which went well and she made a good post-operative recovery.

3) Mrs Mamula was subsequently diagnosed with the rare Loeys-Dietz syndrome at the Genetics Clinic on 24th July 2012.

4) Mrs Mamula remained under annual review by the Cardiology Team at Southampton General Hospital.

5) On 12th June 2013, after having been pain free for 2 years, Mrs Mamula began to suffer with chest pain, which she described as feeling very much like the pain she had felt when she was initially diagnosed with her dissection 2 years earlier. She called an ambulance crew out and they checked her over and could find nothing wrong with her, but with her previous history they suggested that she could be taken to hospital to be checked over. She declined their offer, but agreed that she would see her GP the next day.

6) On 13th June 2013, Mrs Mamula attended her GP's practice and saw [redacted] her GP. Mrs Mamula told her doctor about her chest pain and reiterated that it was the same pain which she had felt some 2 years previously. [redacted] was very concerned and told Mrs Mamula to go straight to A&E. In order to ensure that her patient saw the right doctor in A&E, [redacted] telephoned ahead and spoke to 2 doctors, the first of whom was a physician who said that this was not a matter for him; the second was [redacted] a Staff Associate Specialist in Surgery who agreed to see Mrs Mamula and asked that he be contacted once she was in A&E. [redacted] gave Mrs Mamula a copy of her Encounter printout to show the doctors at the hospital.

7) Mrs Mamula attended A&E with her father. On arrival, she checked in at the Reception Desk and was told to attend the Beacon Centre (GP practice within the Hospital). Upon being triaged there, it became apparent that she needed to be seen by a doctor in A&E, so she and her father were sent back to the A&E department.

8) Mrs Mamula was seen by [redacted] an Associate Specialist in Emergency Medicine at around 15.00 hours. She told him that she had a 2 day history of epigastric pain radiating to her chest. He examined her and found that there was no history of shortness of breath or heart failure. He noted that she had had a thoracic aortic aneurysm repair 2 years earlier. [redacted] was not told that she suffered from Loeys-Dietz syndrome, and indeed he had never heard of such a condition before. He did not recall seeing her Encounter printout which may have been handed in either to Reception or to the Beacon Centre.

9) [redacted] initially diagnosed gastritis with possible gastro-oesophageal reflux and

10) Crucially, the only piece of the patient's presenting history which wasn't passed on to [redacted] was that Mrs Mamula claimed that the pain that she was feeling was the same pain which she had felt back in 2011 when she suffered her previous aortic dissection. Had [redacted] been aware of this piece of information, his evidence was that he would have ordered a CT scan. Without that information he did not have good cause to do so, in his opinion. [redacted] acknowledged that he had not sought out the CT imaging from Southampton General Hospital as it was close to 5 p.m. and he believed that the clerical staff would have left for the day. It is widely acknowledged that a chest x-ray is not definitive when diagnosing an aortic aneurysm, but a CT scan is the "gold-standard" way of diagnosing this condition.

11) Mrs Mamula was discharged from A&E by [redacted] after her symptoms subsided and she had responded well to her treatment for gastritis. She was discharged before seeing [redacted] He came down to A&E later only to find that she'd been discharged, but even though he had had a conversation with [redacted] about her previous condition, he did not attempt to contact her to ask her to return in order that he might examine her.

12) Mrs Mamula was told on discharge from A&E to keep taking her medications on a regular basis, and if she was to become symptomatic again, she should contact A&E again immediately.

13) Five days later, on 18th June 2013, Mrs Mamula's husband returned from his night shift at work and discovered his wife deceased on the floor of the lounge of their house.

14) Life was pronounced extinct by a paramedic at 06.30 hours.

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. During the course of the evidence, it became clear that the Isle of Wight Ambulance Service did not appreciate the gravity of the situation when they were called out by Mrs Mamula on 12th June 2013, inasmuch as they were not aware that Loeys-Dietz syndrome predisposes those who suffer from it to have repeated thoracic aortic aneurysms and dissections. Had they known that this condition was so grave and that Mrs Mamula was complaining of the same pain which she had suffered from 2 years previously which was clearly a very ominous symptom, they could have impressed on Mrs Mamula that she would have been much safer to have been taken to hospital at that point to be thoroughly checked out with a CT scan, which would have been the only definitive way to ascertain if she was suffering a new aortic dissection.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/or your organisation 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 19th January 2015. 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 Lara Mamula. 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	 **H.M. Senior Coroner – Isle of Wight** **24th November 2014**