Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1 **Rt Hon Sajid Javid MP**
Secretary for State for Health and Social Care.....
Dept for Health and Social Care
39 Victoria Street .....
London SW1H 0EU.....

1 CORONER

I am Miss Karin Welsh Assistant Coroner for the area of Teesside and Hartlepool

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 Fourteenth January 2021 I commenced an investigation into the death of Chloe May LUMB aged 24. The investigation concluded at the end of the inquest on 11th February 2022 and established that Mrs Lumb died at [redacted] in Redcar on 8th January 2021. She was known to have a genetic risk of aortic dissection that was being monitored. She presented to James Cook University Hospital Middlesbrough (South Tees NHS Foundation Trust) on 4th January 2021 when a diagnosis of aortic dissection should have been made because of her clinical symptoms and imagining that was carried out. When she contacted the hospital on 5th January 2021because of ongoing symptoms (having been discharged earlier that day) she should have been asked to return. A diagnosis of aortic dissection and appropriate treatment would have prevented her death.

The cause of death was

I a Acute Hemopericardium due to

I b Ruptured Ascending Aortic Dissection due to

I c Cystic Medial Necrosis

My conclusion was that Mrs Lumb died as a result of an undiagnosed and therefore untreated aortic dissection

4 CIRCUMSTANCES OF THE DEATH

Chloe May Lumb died a [redacted], Redcar on 8th January 2021. She was known to have a genetic risk of aortic dissection. She presented at hospital on 4th January 2021 when a diagnosis of aortic dissection should have been made and she should have been asked to return to the hospital on the 5th January 2021. A diagnosis of aortic dissection and appropriate surgical treatment would have prevented death.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows:

There was no clinical guidance or pathway within the Emergency Department of the hospital for patients presenting with suspected aortic dissection that should have included a directive to ensure that an ECG gated CT scan is carried out to exclude the possibility of such condition.
When the Emergency Department were contacted by Ms Lumb on 5th January 2021 there was no mechanism by which staff were alerted to her genetic risk of aortic dissection leading to advice merely to contact her GP

The trust identified these shortcomings prior to the Inquest and have produced a guidance or pathway document for use in the Emergency Department for suspected aortic dissection called 'Management of Adult Patients with Suspected or Proven Acute Aortic Syndromes including Aortic Dissection'. Additionally they produced a Standard Operating Policy to ensure that those patients identified with genetic conditions predisposing to acute aortic syndromes have an Emergency Heath Care Plan and a CPI flag

Copies of both documents are attached

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.

All Trusts within England should be made aware of the circumstances of this case and particularly the necessity to have in place a similar guidance or pathway document and standard operating policy to be achieved via the nhs patient safety framework

7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 13 April 2022. 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.

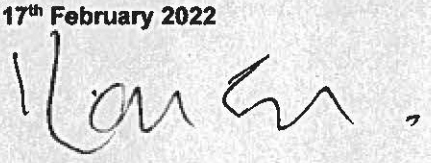
8 COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons
Family
South Tees NHS Foundation Trust

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
17th February 2022



Karin Welsh
HM Assistant Coroner for Teesside and Hartlepool