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 **THIS REPORT IS BEING SENT TO:** **1.** The Right Honourable Matt Hancock MP, Secretary of State for Health, Department of Health and Social Care, 39 Victoria Street, London SW1H 0EU **2.** Ms Karen Partington, The Chief Executive, Lancashire Teaching Hospitals NHS Foundation Trust, Royal Preston Hospital, Sharoe Green Lane, Fulwood, Preston PR2 9HT **3.** Sir Michael Deegan CBE, The Chief Executive, Manchester University NHS Foundation Trust, Cobbett House, Manchester Royal Infirmary, Oxford Road, Manchester M13 9WL **4.** Ms Jane Tomkinson OBE, The Chief Executive, Liverpool Heart and Chest Hospital NHS Foundation Trust, Thomas Drive, Liverpool L14 3PE
1	**CORONER** I am Alan P Walsh, Area Coroner for the Coroner Area of Manchester West.
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 the 9th April 2018 I commenced an Investigation into the death of Angela Mary Jackson, 81 years, born on the 29th May 1936. The Investigation concluded at the end of the Inquest on the 11th September 2018. The medical cause of death was:- Ia Ruptured Thoracic Aortic Anyresum The Conclusion of the Inquest was Natural Causes.
4	**CIRCUMSTANCES OF THE DEATH** 1. Angela May Jackson (hereinafter referred to as "the Deceased") died at the Royal Albert Edward Infirmary, Wigan on the 31st March 2018.

2. On the 29th March 2018 the Deceased was admitted to the Emergency Department at the Royal Albert Edward Infirmary, Wigan (hereinafter referred to as "the Wigan Hospital") at approximately 11.20 hours with a 3 day history of right lower chest and upper quadrant abdominal pain. A CT pulmonary angiogram excluded a pulmonary embolism but identified a 9.5cm descending thoracic aortic aneurysm, the aneurysm extended to the abdomen and in addition the arch of the aorta above the descending thoracic anyreusm was also aneurysmal. Essentially the process involved most of the aorta but there was no evidence of rupture of the anyreusm.

3. At or about 20.04 hours on the 29th March 2018 a doctor from the Wigan Hospital referred the Deceased to the Vascular Surgery Department at the Royal Preston Hospital, (hereinafter referred to as "the Preston Hospital") and the Preston Hospital advised that the scans would be reviewed and "arranged for transfer". When there was no response from the Vascular Surgeons at the Preston Hospital, a doctor from the Wigan Hospital telephoned the Vascular Registrar on call at the Preston Hospital at 11.33 hours on the 30th March 2018 and the Registrar at Preston confirmed that the Deceased would be discussed with the Interventional Radiologist at a Multi-Disciplinary Team meeting later that day.

   At 16.30 hours the Vascular Registrar from the Preston Hospital telephoned the Wigan Hospital and left a message that the Multi-Disciplinary Team recommendation was to refer the Deceased to a Cardiothoracic Centre where such aneurysms might be considered for repair and the Wigan Hospital was advised to contact the "Wythenshawe Cardiothoracic Team", which was the Cardiothoracic Team at Whythenshawe Hospital, Manchester (hereinafter referred to as "the Wythenshawe Hospital"). The Cardiothoracic Surgery Department at the Wythenshawe Hospital is a Consultant led service and at 20.05 hours on the 30th March 2018 the Consultant advised that a descending thoracic aneurysm (as opposed to an ascending aortic aneurysm or dissection) was not routinely dealt with by them and, if the patient required an urgent surgical repair, such repairs should be managed by the regional Aortic Centre at Liverpool and a doctor at the Wigan Hospital was advised to refer the Deceased to the Liverpool Heart Centre.

4. The Liverpool Heart Centre is actually the Liverpool Heart and Chest Hospital (hereinafter referred to as "the Liverpool Hospital").

   Between 01.30 hours and 02.00 hours on the 31st March 2018 a doctor from the Wigan Hospital contacted a doctor from the Liverpool Hospital and spoke to the Cardiology Registrar on call at the Liverpool Hospital. The Registrar at Liverpool Hospital informed the Wigan doctor that he was referring the patient to the wrong speciality and advised him to speak urgently with an Aortic Surgeon, either Vascular or Cardiothoracic. The Registrar gave evidence at the Inquest that the Liverpool Hospital had three main departments, namely Cardiothoracic Surgery, Cardiology and Respiratory Medicine but he did not offer to

	connect the doctor from the Wigan Hospital to the Cardiothoracic department and he did not give details of the three separate departments, except to say that the doctor had contacted the wrong speciality. In view of the fact that the Registrar advised the Wigan doctor to speak urgently with an Aortic Surgeon, either Vascular or Cardiothoracic, the Wigan doctor contacted the Preston Hospital again to speak to a Vascular Surgeon. The Preston Hospital was contacted at 02.27 on the 31st March 2018 and the Registrar at the Preston Hospital confirmed that the referral would be discussed with the Consultant and the Preston Hospital would contact the Wigan Hospital following that discussion. 5. At or about 02.37 hours the Deceased became clammy and reported pain as pleuritic type right sided pain and the Wigan doctor contacted the Preston Hospital who informed him that the Deceased was not for Vascular input and the doctor should contact a Cardiothoracic Surgeon. At that time the Deceased was stable and it was decided that there would be further discussions with the Cardiothoracic Surgeon later in the morning. 6. At approximately 04.00 hours the Deceased suffered a cardiac arrest following and she died.
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 Inquest evidence was heard that:- i. The treatment of an aortic aneurysm depends on the position of the aneurysm. In general terms aneurysms above the diaphragm are referred to as thoracic aneurysms and should be treated by cardiothoracic surgeons and aneurysms below the diaphragm are referred to as abdominal aneurysms and should be treated by vascular surgeons. The treatment of a thoracic aneurysm by a Cardiothoracic Surgeon may also depend on the position of the aneurysm above the diaphragm. An ascending thoracic aneurysm could be dealt with by local Cardiothoracic Surgeons at the Wythenshawe Hospital in Greater Manchester, whereas a descending thoracic aneurysm should be referred to and managed by the Regional Aortic Centre in Liverpool, namely the Liverpool Hospital. ii. The Wythenshawe Hospital referred to the Liverpool Hospital as the Liverpool Heart Centre and advised the Wigan Hospital to contact the

	Liverpool Heart Centre. Clearly, the Liverpool Heart Centre does not exist and the correct referral should have been to the Liverpool Heart and Chest Hospital. iii. There are no written protocols or pathways in relation to the treatment of aortic aneurysms in Greater Manchester or the North West of England, although the Preston Hospital has started to prepare a written Acute Aortic Syndrome Pathway. However, the Acute Aortic Syndrome Path is only in draft form, which has not been approved and which is not in existence. iv. The absence of documented pathways in relation to the treatment of aortic aneurysms is a national problem, which needs to be addressed to enable local district hospitals to be aware of the pathway and to have clear, unequivocal direction for referral of patients with appropriate and correct lines of referral, including the correct names of hospitals and direct telephone numbers and email addresses to ensure efficient and expedient referrals to appropriate hospitals and appropriate surgical teams. v. The referral of patients for the treatment of aortic aneurysm, in many cases, requires an urgent referral and emergency treatment and in my opinion there is a risk that future deaths will occur unless action is taken to consider clear and unequivocal pathways for the referral of patients requiring such treatment. 2. I request the Trusts governing the Preston Hospital, the Wythenshawe Hospital and the Liverpool Hospital to review the referral systems and to consider clear and unequivocal documented pathways for the treatment of patients with aortic aneurysms and the distribution of such documented pathways to district Hospitals and all healthcare professionals within the areas serviced by their Hospitals. 3. I request the Secretary of State for Health to review guidance and direction given to all vascular surgery and cardiothoracic surgery departments in the United Kingdom in relation to the referral and treatment of patients with aortic aneurysms, with particular reference to clear and unequivocal documented pathways as referred to above.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe that 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 by Monday 19th November 2018. 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], Mrs Jackson's granddaughter, [redacted], 2. Mr Andrew Foster CBE, Chief Executive, Wrightington, Wigan and Leigh NHS Foundation Trust, Royal Albert Edward Infirmary, Wigan Lane, Wigan WN21 2NN 3. [redacted], Solicitor, Wrightington, Wigan and Leigh NHS Foundation Trust, Royal Albert Edward Infirmary, Wigan Lane, Wigan WN21 2NN 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	**Dated** **26th September 2018**	**Signed** **Alan P Walsh-** **HM Area Coroner**