IN THE SURREY CORONER'S COURT

IN THE MATTER OF: ANDREW SPENCER WING

The Inquest Touching the Death of Andrew Spencer Wing

A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: • **Dr Katherine Henderson, President of the Royal College of Emergency Medicine** • **Dame Clare Marx Chair of the General Medical Council** • **Sue Webb, President of the College and Society of Radiographers**
1	**CORONER** Caroline Topping HM Assistant Coroner, for the County of Surrey
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** An inquest into the death of Andrew Spencer Wing was opened on 23rd May 2019 and resumed on the 2nd April 2020 and concluded on 6th March 2020 I concluded with a narrative conclusion that: Andrew Wing suffered an acute onset of pain in his chest at 1am on the 13th January 2019. He attended at St Peter's Hospital, Chertsey at 16.47 where he was seen in the minor injuries department by which time his pain had diminished and presented as mild. He underwent investigations which ruled out a myocardial infarction. An aortic dissection was one of the differential diagnoses the possibility of which was recognised and for which the necessary diagnostic investigation was a CT Aorta. Despite the index of suspicion being sufficient to require this to be undertaken it was not and had it been it would have identified an aortic dissection. He was discharged and died from the effects of the aortic dissection on the 15th January 2019 at the Ship Hotel in Weybridge. Had a dissection been identified on the 13th January 2019 prior to discharge he would have been subject to the necessary emergency surgery which he would have survived. The cause of death was : 1a Haemopericardium 1b Aortic Dissection 1c Hypertension I concluded with the narrative conclusion set out above.
4	**CIRCUMSTANCES OF THE DEATH** Andrew Wing had a long history of untreated hypertension having refused medication for the condition. In the early hours of the 13th January 2019 he suffered an acute onset of severe pain in his left side. He attended St Peter's Hospital, Chertsey by which time the pain had diminished. He underwent investigations, an ECG, Chest Xray and blood tests. The blood tests did not show a rise in troponin levels. The Chest Xray was read by 2 emergency clinicians who thought it appeared

	normal. He was discharged from hospital and died on the 15th January 2020 from the effects of the aortic dissection. Aortic dissection was one of the differential diagnoses considered but a CT Aorta was not undertaken.
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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – The evidence showed that: 1. The chest Xray taken on the 13th January 2019 showed an image which was at least at the upper end of normal and in the context of a differential diagnosis of aortic dissection should have led to a CT Aorta being undertaken. Plain X rays are not diagnostic of aortic dissections. The consultant radiographer who reviewed the X ray remotely on the 14th January 2019 reported it as normal but had not been made aware of the differential diagnosis of aortic dissection. If he had been made aware of this he would have advised that a CT Aorta be undertaken. 2. It is common practice for reviews of X rays to be undertaken by radiographers. The clinical information provided to them is sparse. More detailed and specific information would assist them in undertaking their reviews.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 29th May 2020, 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; [redacted] St Peter's Hospital, Chertsey. 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	**Signed:** **Caroline Topping** **Dated this 3rd April 2020.**