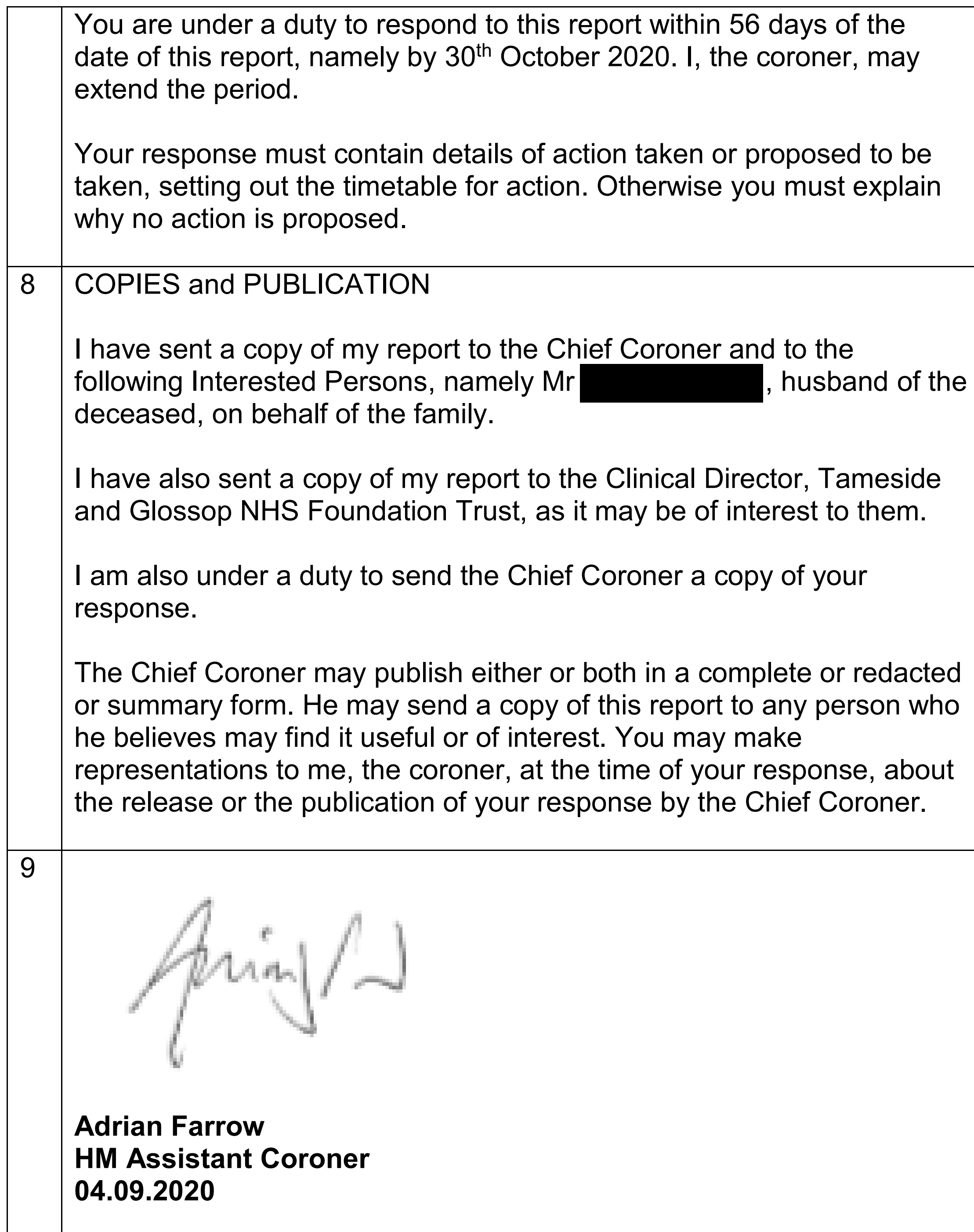
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Director, National Institute for Health and Care Excellence
1	CORONER I am Adrian Farrow, Assistant Coroner for South Manchester
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 30th July 2019, an inquest was opened into the death of Zoe Amanda Knight, who died at Tameside General Hospital on 15th July 2019 at the age of 43 years. The investigation concluded with an inquest which I heard on 28th August 2020. The conclusion was **Narrative: Died as a result of a rare, naturally occurring Aortic Dissection which ruptured before the condition could be diagnosed.**
4	CIRCUMSTANCES OF THE DEATH Mrs Knight woke in the early hours of the morning with chest pain. She had no medical history of any cardiac disorder. She experienced paraesthesia of her right leg and episodes of vomiting and diarrhoea. Having been taken by ambulance to hospital, she was under investigation for ischaemic heart disease and pulmonary embolism, but suffered a brief seizure. Having been referred to the radiology department for a CT head scan and a chest X-ray, Mrs Knight's condition quickly deteriorated and extensive efforts to resuscitate her were unsuccessful. Whilst the doctor assessing Mrs Knight in the Emergency Department was aware of aortic dissection, his focus was on ischaemic heart disease and pulmonary embolism and the origin of the seizure. She was in hospital for about 7 hours. A post mortem examination concluded that Ms Chapman died as a consequence of:

	1a) Dissecting aneurysm of thoracic aorta; and **2) Renal transplant (2006)**
5	<u>CORONER'S CONCERNS</u> 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. I heard from Dr [redacted], a Consultant Cardiologist at Tameside general Hospital that aortic dissection is a well-recognised, but rare condition. It has some characteristic symptoms, but these are by no means definitively diagnostic. 2. There is an overlap of the symptoms of aortic dissection with other cardiac conditions, which can impede or delay the process of diagnosis. Rupture of the aorta following dissection as suffered by Mrs Knight is a catastrophic event. 3. Dr [redacted] was aware of the recommendation made by the Healthcare Safety Investigation Branch – Delayed Recognition of Acute Aortic Dissection (Healthcare Safety Investigation I2017/002b – January 2020 Edition) which contained Safety recommendation R/2020/066: "It is recommended that the Manchester Triage International Reference Group considers the addition of *'aortic pain'* to the Manchester Triage System as a discriminator for chest pain, to raise awareness of acute aortic dissection as a potential cause." 4. It does not appear that this recommendation has been implemented. 5. Dr [redacted]'s evidence was that awareness of aortic dissection was primarily through case-based learning but acknowledged that the recommendation from thee Healthcare Safety Investigation Report above would additionally raise awareness at the triage stage.
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 by 30th October 2020. 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, namely Mr [redacted], husband of the deceased, on behalf of the family. I have also sent a copy of my report to the Clinical Director, Tameside and Glossop NHS Foundation Trust, as it may be of interest to them. 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	 **Adrian Farrow** **HM Assistant Coroner** **04.09.2020**