REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: [redacted], Group Chief Executive, Manchester University NHS Foundation Trust.

CORONER

I am Chris Morris, Area Coroner for Manchester South.

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.
http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7
http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST

On 27th January 2023, Lauren Costello, Assistant Coroner opened an inquest into the death of Benedict Peters who was found dead on 12th November 2022 whilst staying at his parents' home, aged 25 years. The investigation concluded with an inquest which I heard on 4th May 2023.

A post mortem examination confirmed that Mr Peters died as a consequence of:

1a) Haemopericardium;

b. Acute aortic dissection.

The conclusion of the inquest was a narrative conclusion to the effect that Mr Peters died as a consequence of complications arising from an underlying heart defect which had not been diagnosed during his life.

CIRCUMSTANCES OF THE DEATH

Mr Peters was found dead at his parents' home on 12th November 2022 having been staying there following his discharge from the Manchester Royal Infirmary Ambulatory Care Unit the previous day.

Mr Peters had attended hospital in the early hours of 11th November 2022 having become acutely unwell with chest pain, shortness of breath, a sore throat and an aching arm. In the Emergency Department, an ECG was undertaken which was reported as showing Normal Sinus Rhythm and his recorded observations were essentially normal.

Whilst awaiting review, Mr Peters experienced a severe episode of vomiting.

Blood tests were taken and Mr Peters' Prothrombin time was noted to be abnormal. Troponin and D-Dimer levels were within normal limits.

Mr Peters was reviewed on the Ambulatory Care Unit by a Physician Associate. A Chest X-Ray was performed which was reported as being normal and following discussion with the duty Consultant,

Mr Peters was discharged with a diagnosis of panic attack / gastric inflammation and a prescription of Propranolol and Omeprazole.

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. –

It is a matter of concern that despite the patient's reported symptoms, in view of his age and extensive family history of cardiac problems, Mr Peters was discharged from the Ambulatory Care Unit without being examined / reviewed in person by a doctor.

It is a further matter of concern that (according to the evidence of [redacted], Consultant Physician) no policy or protocol exists within the Trust as to when patients may or may not be discharged from the Ambulatory Care Unit without a medical review taking place.

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by **11th July 2023**. 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to Mr Peters' parents and the Trust's legal services department.

I have also sent a copy to the Care Quality Commission and the Greater Manchester Integrated Care Partnership who may find it useful or of interest.

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.

Dated: **16th May 2023**

Signature: Chris Morris, Area Coroner, Manchester South.