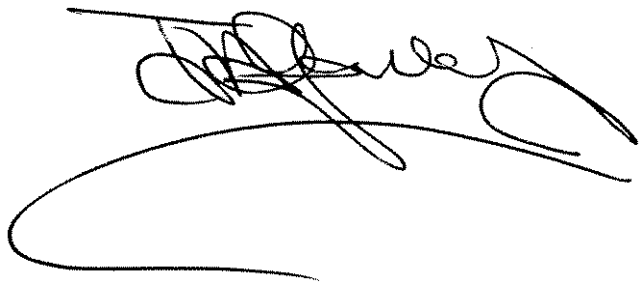
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 [redacted], Rocky Lane Medical Centre, Liverpool, L16 1JD**
1	**CORONER** I am Julie GOULDING, Senior Coroner for the coroner area of Sefton, St. Helens and Knowsley
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	On 01 July 2022 I commenced an investigation into the death of Wayne MILNE aged 43. The investigation concluded at the end of the inquest on 17 October 2023. The conclusion of the inquest was that: Narrative - Wayne Milne died a natural cause of death from sudden and catastrophic consequences of his aorta rupturing and leading to his death. Wayne had attended AED on 28/02/2022 with chest pain amongst other symptoms but the doctor failed to follow the protocols in place, a cardiac/related cause was not considered, a senior doctor was not consulted and Wayne was discharged. On 02/03/2022 Wayne called his GP practice at 08.00 hours, he spoke with the practice manager who was not given any information and at 08.02 the practice manager referred Wayne for a return phone call by a nurse, (he preferred a phone call to attending for a medical appointment) which was made at 10.25. Wayne had complained of chest pain which commenced again after he left hospital, (but was not present at the time of the consultation), a pulsation at the back of his head and discomfort when lying on his side, he was told to seek immediate medical attention and to attend the accident and emergency department. The nurse did not call 999 or discuss Wayne's clinical symptoms with a doctor. Wayne was subsequently found unresponsive by a family member who had become concerned at 14.43, all attempts at CPR were unsuccessful and it is not known what time Wayne suffered the final catastrophic event. The doctor failed to follow the low risk chest pain protocol and the nurse did not call 999 when she could have done, nor did she call back to check that Wayne had gone to hospital/called an ambulance. Earlier appropriate intervention on these two occasions may (possibly) have affected the outcome for Wayne but earlier appropriate intervention would have been likely to have led to Wayne receiving the correct diagnosis/differential diagnosis and potentially life-saving treatment being commenced.
4	**CIRCUMSTANCES OF THE DEATH** Wayne attended hospital on 28/02/22, he was discharged without the protocols in respect

	of chest pain being followed, i.e. there was no 2nd ECG, no 2nd Troponin levels and no consultant review even though there should have been. On 02/03/22 Wayne called the GP practice at 08.00 hours, he received a call from a nurse at 10.25, he reported experiencing chest pain, pain when lying on his side and a pulsation at the back of his head since discharge (he was not c/o chest pain during the call). Wayne was told to go to AED (See ROI) , 999 call was not made on behalf of Wayne and the matter was not escalated to a doctor, the nurse did not follow the call up to see if Wayne had attended hospital, call the hospital or the family, even though ion evidence the nurse said an Aortic Aneurysm was one of the differential diagnoses she considered. Wayne was found deceased at c14.38, at his home. The cause of death being 1a Haemopericardium, due to 1b Dissecting Aneurysm of the Aorta II Covid 19.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) 1. The concerns within the hospital and non-compliance with the LRCP protocol has been addressed by way of an investigation & action plan. 2. The nurse at the practice told the Inquest, the procedure for practice staff calling 999 (not leaving it to the patient) in the event of a patient with chest pain and other life threatening conditions applied only to reception staff and not to nursing staff. This led to inconsistency and in this case an avoidable delay in summoning urgent medical assistance and needs reviewing/all staff working in/working on behalf of the practice need to be aware of the procedure to be followed, consideration must be given as to whether it is appropriate to have different standards for qualified nursing and administrative/non qualified nursing staff. The awareness of Dissecting Aortic Aneurysm and the rapidity at which the condition can become catastrophic/fatal also needs raising within the practice. The nurse within the practice who spoke with Wayne on the date of his death on behalf of the practice , did not escalate to a doctor, did not call 999, she did not inform the NOK of her concerns, she did not call back to see if Wayne had called for an ambulance/attended hospital and she did not alert the hospital of her suspicions i.e. differential diagnoses including; PE, cardiac related problem or aortic aneurysm. The GP to whom this regulation 28 (Prevention of Future death) report is addressed informed the court (in a witness statement) no action had been taken within the practice since these events.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by December 14, 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested

	Persons [redacted] **(NOK)** I have also sent it to: [redacted] **-** Head of Quality and Safety Improvement NHS Cheshire and Merseyside ICB **Whiston Hospital Legal Services** who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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: 19/10/2023**  **Julie GOULDING** **Senior Coroner for** **Sefton, St. Helens and Knowsley**