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:** **NHS England** **7 and 8 Wellington Place** **Leeds** **LS1 4AP**
1	**CORONER** I am Jacqueline DEVONISH, Senior Coroner for the coroner area of Cheshire
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 02 January 2024 I commenced an investigation into the death of Thomas Geoffrey WAKEFIELD aged 79. The investigation concluded at the end of the inquest on 10 April 2024. The conclusion of the inquest was that: Thomas Wakefield died from natural causes. It is not possible to say on balance of probabilities whether Mr Wakefield would have survived if the correct diagnosis had been made on admission.
4	**CIRCUMSTANCES OF THE DEATH** On 22 September 2023, 79 year old Thomas Wakefield was admitted to Countess of Chester Hospital at 22:22 hours with a three day history of severe stomach pain and sudden collapse at home in the early afternoon. The clinicians were not made aware of the collapse at home. He was promptly assessed in A&E for concerns with acute kidney injury. The plan was to prescribe intravenous fluids due to hypotension. There was a delay in medical assessment. A CT scan was considered at 05:59 but not ordered or completed. This was a missed opportunity to review the diagnosis of pancreatitis on admission and provide a 50% chance of survival. He was sadly found deceased in bed at 16:10 hours on 23 September 2023.

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: During a review of the NICE guidelines entitled "Abdominal Aortic Aneurysm: diagnosis and management", and the international guidance, it became apparent that there is a lack of caution within the guidance about the recognised risk that abdominal aortic aneurysm and acute pancreatitis are known to be diagnoses misidentified by clinicians. These conditions can have similar presenting features. Whilst the guidance states that if there is uncertainty about a diagnosis of pancreatitis as not all criteria are met, imaging tests should be undertaken, this does not specifically require the exclusion of abdominal aortic aneurysm which is fatal if untreated. The clinical presentation alongside amylase results in this case met the criteria for a diagnosis of pancreatitis.
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 June 12, 2024. 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 **Mr Thomas Wakefield's family** **Countess of Chester Hospital** 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: 17/04/2024** **Jacqueline DEVONISH** **Senior Coroner for** **Cheshire**