Kally Cheema LLB | Senior Coroner | Cumbria

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Case Ref: **10350934**

9 July 2024

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: [redacted] **Medical Director, University Hospitals Morecambe Bay Trust.**

CORONER

1 I am Dr Nicholas Shaw HM Assistant Coroner for Cumbria

CORONER'S LEGAL POWERS

2 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 22 November 2023 I commenced an investigation into the death of Nancy ROGERS. The investigation concluded at the end of the inquest . The conclusion of the inquest on 9th July 2024 was

Death from natural causes. The medical cause of death being

3 1a Bilateral Haemothorax

1b Ruptured Dissecting Aortic Aneurysm

1c

II

I also refer to an inquest opened on 10th August 2023 and concluded on 23/11/23 touching on the death on 12th February 2023 of [redacted], the medical cause of death being 1a Haemopericardium due to 1b Ruptured Dissecting Aortic Aneurysm

4 **CIRCUMSTANCES OF THE DEATH**

18/11/2023- Nancy collapsed outside on Storey Square, Barrow when she was walking with her sister [redacted] into town. This occurred around 1300hrs. An ambulance was called and Nancy attended A&E. She had tests done however the results were not back and they are due to come back on Monday 20/11/2023. Hospital discharged Nancy back to her home address. They stated she possibly had fluid on her lung which would need a referral. On 19/11/2023 at around 0530hrs [redacted] helped Nancy to the toilet; she left the bathroom to give Nancy some privacy and immediately heard her fall. [redacted] went into the bathroom and Nancy was not breathing. CPR was started and the neighbour [redacted] came over as she heard the shouting through the wall. No response to CPR from family attempts and paramedics arrived to continue. Nancy is in the process of selling her home to return to the Philippines and this has been causing her some stress.

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. –

[BRIEF SUMMARY OF MATTERS OF CONCERN]

5 (1) At the inquest into Shirley Potter's death the hospital report indicated no learning was required as her presentation was not typical. The circumstances in both these cases are remarkably similar in that both ladies attended the emergency department at Furness General and were allowed home only to die within a day of the same cause and as far as the attending clinician at today's hearing knew no learning or teaching has taken place since Nancy's death.

(2) As a coroner I am not permitted to suggest what actions might be taken but feel it safe to mention NHS futures Aortic Dissection Toolkit and The Aortic Dissection Charitable Trust for further information.

(3)

ACTION SHOULD BE TAKEN

6 In my opinion action should be taken to prevent future deaths and I believe you and the wider Trust 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,
7 namely by 3rd September 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested
8 Persons: [redacted], [redacted]. I have also sent it to [redacted] 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.

9 July 2024

9 Signature 

Dr Nicholas Shaw HM Assistant Coroner for