OFFICE OF THE
SENIOR CORONER
for the County of West Yorkshire
(Eastern District)

His Majesty's Coroner's Office
The Coroner's Courts
Burgage Square
Wakefield WF1 2TS

Telephone: [redacted]
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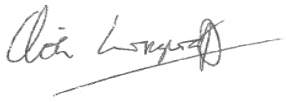
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

1.	**THIS REPORT IS BEING SENT TO:** **1.** West Yorkshire Integrated Care Board (ICB), White Rose House, West Parade, Wakefield WF1 1LT
	CORONER I am Oliver Robert Longstaff, Area Coroner for the Coroner Area of West Yorkshire (East).
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 06 September 2024 I commenced an investigation into the death of Chloe Alicia Ellis who died on 03 September 2024 in Leeds General Infirmary. The investigation concluded at the end of the Inquest on 09 June 2025. The medical cause of death was 1a) Pulmonary Embolism; 1b) Endometriosis, Treated with Oral Contraceptive Pill. In summary, the narrative conclusion to the inquest was that, had a history of her oral contraceptive use been obtained when Chloe attended a local hospital Emergency Department on 31 August 2024, she would have been given anticoagulation medication and undergone tests that would have revealed the pulmonary embolism. She would have received effective treatment for the pulmonary embolism and, on the balance of probabilities, would not have died three days later.
4	**CIRCUMSTANCES OF THE DEATH** Chloe Ellis had been taking the Yasmin contraceptive pill to manage her endometriosis since September 2023. On 31 August 2024 she undertook an NHS 111 online assessment in which she reported chest and back pain and breathlessness and gave a history of her oral contraceptive use. The

	assessment algorithm advised her to attend a local Emergency Department, having concluded via the algorithmic process that she had a suspected pulmonary embolism. The assessment algorithm did not tell Chloe herself that she had a suspected pulmonary embolism. The outcome of the NHS online assessment was not available to clinical staff at the Emergency Department at Dewsbury District Hospital where Chloe attended. There, an inadequate history was obtained from her, in that she was not asked about her medication history and specifically about her use of oral contraception. The inquest was informed of measures taken by the Mid Yorkshire Teaching NHS Trust in relation to that inadequate history taking, and no Reg 28 report is being made in respect of it. Chloe was diagnosed with a viral illness and discharged. She collapsed at home on 03 September 2024 and, despite the best efforts of attending paramedics and clinicians at Leeds General Infirmary, she died later that day.
5	**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. – (1) The inquest was told that it is possible for the outcomes of NHS 111 online assessments to be made accessible to Emergency Department clinicians, and that the decision whether or not to commission that accessibility in a particular hospital rests with the relevant Integrated Care Board. (2) The inquest was told that the West Yorkshire Integrated Care Board has not commissioned accessibility to NHS 111 online assessments for the Mid Yorkshire Teaching NHS Trust. (3) If the NHS online assessment completed by Chloe had been available to the relevant clinicians at Dewsbury District Hospital, her history of oral contraceptive use and the suspicion of a pulmonary embolism would have been visible to them. (4) The availability of NHS 111 online assessments to clinicians in Emergency Departments may assist in the obtaining of a full history and may act as a failsafe against inadequate history taking in Emergency Departments.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 08 August 2025. 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: Chloe's family; Mid Yorkshire Teaching NHS Trust. 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	**Signed:**  OLIVER LONGSTAFF Area Coroner West Yorkshire (East) **Date:** 13 June 2025