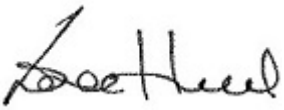
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • Secretary of State for Health • University Hospitals Birmingham NHS Foundation Trust
1	**CORONER** I am Louise Hunt, Senior Coroner for Birmingham and Solihull
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 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 7 January 2025 I commenced an investigation into the death of Mark Anthony VILLERS. The investigation concluded at the end of the inquest . The conclusion of the inquest was; Died from a dissection of the ascending aortic which went undiagnosed before his death.
4	**CIRCUMSTANCES OF THE DEATH** Mr Villers attended Good Hope Hospital on 18/05/24 having developed severe chest pain the previous evening which he described to staff as central chest pain radiating into the upper back and shoulders. He was initially assessed as likely suffering from alcohol induced gastritis however the description of pain should have resulted in aortic dissection being considered on the list of differential diagnoses. Mr Villers continued to suffer significant pain despite being given strong pain relief. A CT scan was undertaken to exclude any intra-abdominal pathology which was excluded, however the scan identified a renal infarct. It was not appreciated that renal infarction in an otherwise fit and well man was an unusual finding and an indicator of aortic dissection. At the time of the CT scan the aorta was reported to be normal. Retrospective review after Mr Villers death confirmed that the CT scan did show a subtle intimal flap in the descending thoraco abdominal aorta which if spotted would have resulting in further tests to confirm the diagnosis of aortic dissection. At 14.27 on 18/05/24 a junior doctor recorded that aortic dissection needed to be ruled out by CT angiogram however when Mr Villers was later reviewed on the ward round no further tests were undertaken and it was not appreciated that his presentation, ongoing pain despite pain medication and renal infarction all pointed to a possible diagnosis of aortic dissection. Mr Villers was discharged home on 19/05/24 to return on 22/05/24 for further tests associated with the renal infarct. He remained unwell at home and represented to Good Hope hospital on 20/05/24. At this time it was determined he was likely suffering from infected gall stones based on a raised C reactive protein and white cell count and ultra sound scan. Overnight his observations remained normal and he was last seen at 05.18 when no concerns were noted. He was found collapsed in bed at 08.20 and sadly could not be resuscitated. Post mortem examination confirmed he died from a dissection of the ascending aorta. Following a post mortem the medical cause of death was determined to be: **1a HAEMOPERICARDIUM** **1b DISSECTION OF THE ASCENDING AORTA AND BEYOND**

	1c **1d** **II**
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 investigation by the hospital trust identified that at the time of Mr Villers' presentation to hospital on 18/05/24 there were insufficient radiologists to report the large number of CT scans undertaken over the weekend period. This was one of the root causes of the very subtle abnormality indicating aortic dissection being missed when the scan was reported. The inquest heard evidence that whilst the situation had improved the number of radiologists was still not in accordance with Royal College of radiology guidelines thus creating a risk of future deaths and in my view, action should be taken.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 29 July 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: The family of Mr Villers I have also sent it to the Medical Examiner, ICS, NHS England, CQC, 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. She may send a copy of this report to any person who she 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	**3 June 2025**

	Signature:  **Louise Hunt** **Senior Coroner for Birmingham and Solihull**