



REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. Chief Executive of Nottingham University Hospitals NHS Trust (“the Trust”).
1	CORONER I am Nathanael Hartley, Assistant Coroner for the coroner area of Nottingham and Nottinghamshire.
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 12 August 2024 an inquest was opened into the death of David Charles Noel Jones, aged 65. The inquest concluded on 2 September 2025. I made a narrative determination at inquest that he died as a result of an aortic dissection.
4	CIRCUMSTANCES OF THE DEATH Mr Jones had attended hospital following an episode of dizziness. He was reviewed in the Emergency Department and noted to have low blood pressure and a low pulse rate. He was monitored within Resus before being stepped down to Majors whilst awaiting admission to ward B3 for monitoring of his blood pressure and kidney function. Mr Jones had an incident of chest pain and sweatiness whilst mobilising when he was in Majors. That was not brought to the attention of a senior doctor and did not result in a further clinical assessment and consideration of further investigations within resus. Those likely further investigations may well have revealed the presence of an aortic dissection. Mr Jones remained as an inpatient in hospital until the following day when he was discharged and sadly died later that day from the effects of the aortic dissection.
5	<u>CORONER’S CONCERNS</u> During the course of the inquest the evidence 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. This is not the first inquest involving the Trust where there have been concerns about an undiagnosed aortic dissection. I am personally aware of another recent inquest in which evidence was provided to assure the coroner that relevant learning has been disseminated across the appropriate departments at the Trust, and processes amended to try to prevent recurrence. I am also aware of evidence given to my coroner

	colleagues about the Trust's educational programme, particularly for the emergency department team. The MATTERS OF CONCERN are as follows. – 1. Whilst reviews were carried out through the Morbidity and Mortality process for two of the departments involved in Mr Jones' care, one has not been carried out by the Emergency Department, despite concerns raised at inquest by the witness from that team. I am concerned that potential learning, which may make a difference to future patients presenting with atypical aortic dissections, has not been identified or passed on to clinicians within the emergency department and any other relevant departments. 2. Despite Mr Jones' clinical picture changing whilst in the emergency department, the middle grade doctor reviewing Mr Jones did not alert a senior doctor of the change. I am concerned that training in relation to atypical aortic dissections brought to my attention in evidence at this and a previous inquest, and to my coroner colleague's attention in inquests they conducted, may not have been ineffective. I am concerned about recurrence for other patients who present atypically, and that the patients who experience similar significant developments whilst in hospital may remain unreviewed by those with the appropriate skill and seniority, and a risk of death from undiagnosed aortic dissections may follow.
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 9 December, 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: 1. Mr Jones' family. I have also sent a copy to the Chair of the NHS Nottingham and Nottinghamshire Integrated Care Board, for their information.
9	Dated: 14 October 2025 Nathanael Hartley HM Assistant Coroner For Nottingham and Nottinghamshire