REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Mid and South Essex NHS Foundation Trust,** Broomfield Hospital, Court Road, Broomfield, Essex.
1	**CORONER** I am STEPHEN SIMBLET KC assistant coroner, for the coroner area of Essex.
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 21/03/2025, I commenced an investigation into the death of Evie Gladys Muir, who died aged 17. The investigation concluded at the end of the inquest on 26/11/2025. The conclusion of the inquest was death by natural causes. The medical cause of her death was coronary artery vasculitis.
4	**CIRCUMSTANCES OF THE DEATH** The deceased died aged 17 of a heart attack suffered less than 2 weeks after her admission to hospital where she had a week- long stay for treatment for cardiac problems. She suffered with a rheumatological condition axial spondylarthritis for which she was receiving adalimumab medication. She was known to be HLA B27 positive. The deceased was discharged from hospital on 6th February having been provided with various medications. On 19th February, she collapsed with a cardiac arrest from which she could not successfully recover.
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 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. – (1) That hospital reviews into unusual cardiac deaths such as this one are not more widely shared with other clinicians involved with a patient's care, and other disciplines, such as, in this case, rheumatology specialists. This means that the full clinical picture of how a patient died may not be sufficiently widely understood. (2) patients with cardiac problems known to be HLA B27 positive or otherwise known to present rheumatological conditions being

	adequately assessed for the risks which those rheumatological problems might present, include vasculitis. .
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 25th January 2026. 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 : (i) [redacted] and [redacted], parents of the deceased; (ii) to the LOCAL SAFEGUARDING BOARD (where the deceased was under 18)]. (iii) [redacted], Child Death Review Team Lead. I have also sent it to the Department of Health 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	[redacted] **26th November 2025** **Stephen Simblet KC** **Assistant Coroner**