North Middlesex
University Hospital

NHS
Royal Free London
NHS Foundation Trust

North Middlesex
University Hospital
Sterling Way
London
N18 1QX

28th April 2026

Alison Hewitt
HM Senior Coroner for City of London
City of London Coroner's Court
4th Floor
Central Criminal Court
Old Bailey
London

Dear Coroner,

Re: Prevention of Future Deaths Report – Ms Jennine Romeo who died on 4th June 2025

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 10th March 2026 concerning the death of Ms Jennine Romeo on 4th June 2025.

In advance of responding to the specific matters of concerns raised in your Report, I would like to express my deep condolences to Ms Romeo's family and loved ones. North Middlesex University Hospital is keen to assure the family and yourself that the areas raised as part of the evidence at the Inquest have been listened to and reflected upon.

Your Report raised a concern regarding the lack of system in place to escalate and review abnormal findings on transthoracic echocardiogram. We can assure you that the echocardiography department has an established escalation pathway and protocol on how to action significant abnormal results. The escalation protocol (attached as Appendix 1) has been operational since 2019 with criteria based on best practice and guidelines from the British Society for Echocardiography and includes significant valvular abnormalities, ventricular abnormalities, large pericardial collections, markedly enlarged vessels, abnormal masses and other miscellaneous findings. The pathway clearly outlines the action of escalation which, depending on the findings, will include either on-call Cardiologist review on the day of the scan or a Cardiology Consultant review of results within 2 weeks. The pathway outlines how to escalate, including appropriate email contacts for administrative purposes. The escalation pathway is shared with the cardiac physiologist team and discussed in team meetings to ensure the team are up to date with current pathway. The escalation pathway is reviewed on an annual basis by the departments lead clinicians/physiologist or earlier if the need arises from specific cases.

Your Report raised a concern regarding learning points and action taken following the Hospital's own Mortality Review which took place as part of the Cardiology department's monthly governance meeting on 10th September 2025. The learning points from that meeting were as follows:

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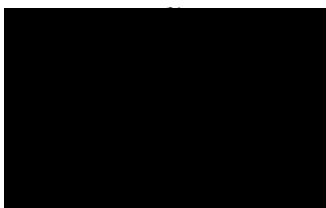
- Paravalvular leaks may present subtly and evolve gradually; TOE should be considered early if there is any uncertainty.
- Right ventricular dilatation and dysfunction are important prognostic and surgical risk markers and should always be factored into decision-making.
- Surgical operative notes should be accessible to imaging and heart failure teams to improve interpretation and continuity of care.
- Cases with uncertainty or diagnostic challenge should be escalated for senior review, with a low threshold for MDT discussion.
- Regular reinforcement, reminders, and refreshers on the recognition of paravalvular leaks should form part of ongoing departmental education.

Learning points from individual cases are discussed in the departmental weekly MDT echo meeting, and in the case of Ms. Romeo the challenges of assessing mechanical valves as well as abnormal change to parameters that one should be aware and need to escalate have been discussed and shared with the wider cardiac physiology team. There are also departmental educational sessions that specifically focus on assessment of valve disease. With regards to specific changes to the escalation pathway following Ms. Romeo's case, the escalation criteria have been reviewed and an additional criterion, detailing the findings of new pulmonary hypertension have been included in the pathway.

Your report raised a concern regarding review of clinical results in a timely manner, whether or not the planned outpatient appointment takes place. Following this a revised process has been introduced to strengthen oversight of appointment cancellations. This has been operational since April 2026. If a patient has their appointment cancelled (by either the service, or patient) they are automatically booked into the next available follow-up appointment slot by the bookings team. If a patient has had their appointment previously cancelled by the service, where it is identified that their next appointment would also be cancelled, the case is escalated to the Cardiology service manager for senior review. The case is then discussed with the relevant clinicians to determine the most appropriate course of action and minimise delay in clinical review where necessary. This aims to ensure consistent decision-making, reduce the risk of repeated cancellations, and improve patient pathway management.

Yours sincerely,



Medical Director