Re : JENNINE SASHA ROMEO DECEASED

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] Medical Director of the North Middlesex University Hospital** **2. [redacted], Chief Medical Director of the Royal Free London NHS Foundation Trust**
1	**CORONER** I am Alison Hewitt, HM Senior Coroner for the City of London.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7 of Schedule 5 to the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** I commenced an investigation into the death of Jennine Sasha Romeo on the 4th June 2025. The investigation concluded at the end of the inquest on the 10th March 2026. The conclusion of the inquest was that the medical cause of death was – Ia Multi Organ Failure Ib Dehiscence of prosthetic mitral valve (Operated on 23.5.25 with re-do sternotomy and mitral valve replacement) Ic Mitral valve regurgitation (Operated on 27.3.24 with mechanical mitral valve replacement) and my conclusion as to the death was that the Deceased,

	"Died as a result of post-operative complications of surgery performed to treat naturally occurring disease and post-operative complications of subsequent re-do surgery".
4	**CIRCUMSTANCES OF THE DEATH** Jennine Romeo suffered mitral valve prolapse and severe mitral regurgitation and, on the 27th March 2024 at St. Bartholomew's Hospital, London, she underwent mechanical mitral valve replacement surgery which was completed without complication. Post-operatively, she was reviewed by the cardiac rehabilitation and valve clinics at the North Middlesex University Hospital. A transthoracic echocardiogram performed in August 2024 showed a well seated prosthetic valve with a trivial leak, and a transthoracic echocardiogram performed in January 2025 showed a well seated prosthetic valve with a mild leak, as well as a newly dilated and impaired right ventricle with severe tricuspid regurgitation and pulmonary hypertension. The January 2025 result was due to be reviewed by the valve clinic, but the Deceased's out patient appointments for February and for March 2025 were cancelled by the hospital, and there is no evidence of any clinical review of the result until May 2025. On the 7th April 2025, the Deceased was reviewed in the cardiac rehabilitation clinic and was found to be breathless on exertion and she was referred to the heart failure team for treatment; on further review on the 30th April 2025, tests revealed acute kidney and liver injuries and she was admitted urgently. A transthoracic echocardiogram performed on the 1st May 2025 showed a dehisced mitral valve and severe paravalvular leak with acute cardiac decompensation. She was transferred to St. Bartholomew's Hospital's intensive treatment unit in a critical condition. Following some improvement, the Deceased underwent challenging and high-risk re-do sternotomy and further mitral valve replacement surgery on the 23rd May 2025. Post-operatively, she was stable, and appeared to be improving, until the 27th May 2025 when there was rising lactate and decreasing urine output. On the 28th May 2025, the Deceased was taken to theatre to drain pericardial effusion but she suffered a cardiac arrest during induction of anaesthesia, necessitating cardiopulmonary bypass and re-sternotomy. The Deceased was resuscitated from this and a subsequent arrest but, despite full support in the intensive treatment unit, she subsequently developed multiorgan failure from which she died on the 29th May 2025. The delay in clinical review of the January 2025 transthoracic echocardiogram result led to a delay in the discovery of the valve dehiscence. Timely review would probably have resulted in further investigations and earlier diagnosis of the dehiscence progression, earlier escalation to the surgical team at St.

	Bartholomew's Hospital, and earlier surgery. If surgery had been performed prior to the Deceased's significant deterioration in April 2025, there may have been a different outcome.
5	**CORONER'S CONCERNS** In 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: As stated above, the evidence suggested that the outcome of a transthoracic echocardiogram performed in January 2025 at the North Middlesex University Hospital was not reviewed by any clinician until May 2025. It seems that the intention was for it to be reviewed at a valve clinic out-patient appointment, but appointments in February and March 2025 were cancelled by the hospital, and there is no evidence to suggest that the result was considered at a paper review by the Consultant on the 4th April 2025, not by any other clinical team at the hospital. There appears to be no system in place to ensure that a result such as this is viewed and considered by a member of a relevant clinical team in a timely manner, whether or not the planned out-patient appointment takes place as planned. Additionally, it seems that there is no relevant pathway for the echocardiography team to flag a result such as this to the clinical team. Although the Hospital's own Mortality Review highlighted a number of learning points, I was not told of any action which has been taken in response to those matters as yet.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths by addressing the concerns set out above and I believe your organisations 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 the 6th May 2026**. I, as 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 should explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner, to the following Interested Persons and to the other organisations listed below which may find it useful or of interest: a. The parents of Jennine Romeo b. Barts Health NHS Trust I am also under a duty to send the Chief Coroner a copy of your response. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
	10th March 2026 **Alison Hewitt**