Chief Coroner

REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

If during an investigation, a coroner becomes concerned about circumstances that create a risk of future deaths, Paragraph 7 of Schedule 5, Coroners and Justice Act 2009, provides coroners with the duty to make reports to a person, organisation, local authority or government department or agency where the coroner believes that action should be taken to prevent future deaths. That report is called a Prevention of Future Deaths Report (PFD report).

The Chief Coroner provides this template to support coroners in the effective and consistent exercise of their statutory duties under the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

The purpose of the template is to provide a clear and structured framework for setting out the matters of concern identified during an investigation which, in the coroner's opinion, give rise to a risk of future deaths. It is designed to promote clarity, ensure that reports are formulated in a way that enables recipients to understand and address the concerns raised, and to support good practice across jurisdictions.

The template does not fetter judicial independence: coroners remain responsible for determining the facts, identifying the matters of concern, and drafting reports that accurately reflect the circumstances of each individual case. The template may be adapted as necessary to ensure that the report properly and precisely records the coroner's views.

In accordance with the Chief Coroner's PFD Publication Policy (2026) any applications for redactions to content or general publication of the report must be sent to the coroner. The coroner will provide the representations to the Chief Coroner for a decision.

REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

1.	**CORONER** I am Mrs Dianne Hocking, Assistant Coroner for the coroner area of Leicester City and South Leicestershire
2.	**DATE OF REPORT** 21 July 2026
3.	**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.
4.	**THIS REPORT IS BEING SENT TO** **Chief Executive Officer** **Nottingham University Hospitals HNS Trust** You are under a duty to respond to this report within 56 days of the date of this report, namely by September 15, 2026. I, the coroner, may extend the period if an appropriate application is made.
5.	**YOUR RESPONSE** 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.

6.	**SUMMARY OF CORONER'S CONCERN** I am making this report before the conclusion of the inquest. See (10)
7.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
8.	**INVESTIGATION AND INQUEST** A Pre-Inquest Review Hearing took place on the 21 July 2026 and the inquest set for 04 September 2026 initially has been put back to possibly October 2026 due to unavailability of witnesses. In my opinion this report cannot wait until the conclusion of the inquest.
9.	**CIRCUMSTANCES OF DEATH** Before Inquest and during the course of my investigations:- Mr Budd died on the 24 February 2026 aged 65 years. He was admitted to the Royal Derby Hospital on the 24 February 2026 at 12:26. He presented with sudden onset left sided jaw pain which radiated to the occipital region and thoracic spine. Suspecting aortic dissection or subarachnoid haemorrhage a CT scan was requested along with a D Dimer at 15:55. He was diagnosed with an aortic dissection following CT scan at 17:45 (reported at 18:03). There was discussion between the Year Two Foundation doctor and the on call cardiac surgeon in Derby. University of Hospital Nottingham cardiac team were contacted who confirmed that they were unable to deal with this type of surgery and Derby was advised to contact Glenfield who agreed to have Mr B admitted for surgery. Adult Critical Care Co-Ordination and Transfer Service (ACCOTS) was contacted and transferred Mr B to Glenfield, arriving at 20:26 in ventricular fibrillation from which he could not be recovered and died at 20:45 despite resuscitation attempts.
10.	**CORONER'S CONCERNS** During the course of the investigation 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. Acute type A aortic dissection is a time critical surgical emergency and your hospital, where in fact the regional aortic dissection lead is based, cannot provide certain emergency surgical interventions that are recommended and expected under established national and international guidance for the management of Type A aortic dissection.

	This leads to referrals of these patients to Glenfield Hospital Leicester at a late stage and following delays caused by non-standardised referral processes and the inevitable delay caused by physical transfer from Nottingham to Glenfield Hospital Leicester. This investigation is the second such death in these circumstances. 2. Cardiac surgeons at Glenfield Hospital Leicester have offered support in the form of mentorship and collaborative operative development in advanced aortic procedures, including frozen trunk surgery to try and lessen the impact of (1) above but this has not been taken up by the Trust.
11.	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: The family of the deceased University of Derby and Burton NHS Foundation Trust. University of Leicester NHS I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
12.	**SIGNATURE** [redacted] **Mrs D HOCKING** **His Majesty's Assistant Coroner for** **Leicester City and South Leicestershire**