

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 Chris Morris, Area Coroner, for the coroner area of Greater Manchester (South)
2.	DATE OF REPORT 26 August 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.
3.	THIS REPORT IS BEING SENT TO 1) The Secretary of State for Health and Social Care - now replaced by NHS England as designated better placed to respond by Department of Health and Social Care. 2) The Chief Executive, Tameside and Glossop Integrated Care NHS Foundation Trust. You are under a duty to respond to this report within 56 days of the date of this report, namely by 21 October 2026. 1, the coroner, may extend the period if an appropriate application is made.

4.	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 <u>Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary</u>.
5.	SUMMARY OF CORONER'S CONCERN This report is made in respect of a range of concerns arising from the evidence relating to provision of healthcare services to patients who attend hospital urgent care settings in England and Wales, and particularly those who present with chest pain.
6.	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.
7.	INVESTIGATION AND INQUEST On 7 August 2024, an inquest was opened into the death of Paula Ivers who died at home on 8 March 2024 aged 47 years. A post mortem examination determined Ms Ivers died as a consequence of: 1)a) Haemopericardium 1)b) Aortic dissection due to cystic medial degeneration. The inquest concluded on 17 June 2026. At the end of the inquest, I recorded the following Narrative Conclusion:

	<i>Paula Ivers died as a consequence of complications arising from an undiagnosed, and therefore untreated, aortic dissection three days after her discharge from a hospital Same Day Emergency Care unit with a diagnosis of Gastroesophageal Reflux Disease. Ms Ivers's death was contributed to by neglect.</i>
8.	CIRCUMSTANCES OF DEATH Paula Ivers died at home on 8 March 2024 as a consequence of complications arising from an undiagnosed aortic dissection. Ms Ivers attended the Emergency Department at Tameside General Hospital, Ashton-under-Lyne, on 5 March 2024 having experienced increasing chest pain radiating to her back since the previous evening. Following triage, an ECG which was considered to be normal, and a paper-based review by the streaming Consultant, Ms Ivers's care was transferred to the Same Day Emergency Care unit ('SDEC'). In SDEC, Ms Ivers's observations were repeated, and she was seen by a junior doctor who took a history, examined her, and arranged for a Chest X-Ray and additional blood tests. The results of all observations and investigations were considered to be normal, save for her heart rate which was elevated when measured and her CRP which was slightly raised. Notwithstanding the nature and extent of the pain reported, and a familial history of early cardiac death, Ms Ivers was discharged home the same day for GP follow up with a diagnosis of Gastroesophageal Reflux Disease, safety-netting advice, and a prescription for Omeprazole. The possibility of thoracic aortic dissection as an explanation for Ms Ivers's symptoms was not considered by the doctors who reviewed her presentation in SDEC and as such, no CT Angiogram was undertaken prior to discharge. Had this investigation been undertaken, it is likely the underlying condition which ultimately led to Ms Ivers's death would have been identified leading to her transfer to a specialist centre for emergency surgery which she probably would have survived.

9.

CORONER'S CONCERNS

During the course of the inquest, I heard evidence 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:

To the Secretary of State for Health and Social Care

- 1) The court heard evidence from the Clinical Lead of SDEC as to a range of factors which he considers have contributed to increased attendances to the Trust's urgent care services. I am concerned that one of the factors cited in evidence related to inability of some patients to obtain appointments at the GP practice they are registered with in a timely manner.
- 2) It is understood from the evidence heard at inquest that NHS Trusts apply varying criteria as to which patients may be seen in an SDEC as opposed to an Emergency Department. It is a matter of concern from the evidence that there currently appears to be no national requirement which mandates early substantive face-to-face review by an experienced doctor or Advanced Practitioner prior to the streaming of a patient.

To the Chief Executive, Tameside and Glossop Integrated Care NHS Foundation Trust

- 1) Notwithstanding the significant amount of work the Trust has undertaken in the light of its investigation into the care afforded to Ms Ivers, it is a matter of concern that key familial history (such as early cardiac death of an immediate family member) is not automatically captured by the initial contact with a clinician.
- 2) I am concerned that patients who present to the Trust with chest pain do not routinely have their blood pressure checked in both arms as a matter of course.

10.	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: <i>[please do not use individual's names, but instead roles/titles]</i> 1) Ms Ivers's family; 2) CareQuality Commission; and 3) NHS Greater Manchester Integrated Care Partnership. 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 <u>PFD Publication Policy (2026)</u>. Any representations will be sent to the Chief Coroner alongside the report. Please refer to box4 above for additional information relating to the publication of reports and responses.
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