MISS N PERSAUD
HER MAJESTY'S CORONER
EAST LONDON
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
Telephone 020 8496 5000 Email [redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Ref: [redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **[redacted], Chief Medical Officer, Barts Health NHS Trust, Ground Floor, Pathology Block, 80 Newark Street, London, E1 2ES Email: [redacted]** 2. **[redacted], Medical Director, North East London Foundation Trust, Suite 1, Phoenix House, Christopher Martin Road, Basildon, Essex, SS14 3EZ Email: [redacted]**
1	**CORONER** I am Nadia Persaud area coroner for the coroner area of East London
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On the 7th November 2019 I commenced an investigation into the death of Mr Paul Sartori, who was 38 years old. The investigation concluded at the end of the inquest on 22nd April 2021. The conclusion of the inquest was a narrative conclusion: *Paul Sartori died from a dissecting aortic aneurysm on the 27 October 2019. He sought emergency medical assistance for central chest pain on the 24 October 2019. He was taken by ambulance to A&E, but directed away from the A&E department, to the urgent care centre by an emergency department nurse. He underwent an assessment by a*

general practitioner in the urgent care centre. The general practitioner formed the impression of costochondritis (musculoskeletal chest pain). Mr Sartori was advised to take analgesia and to seek medical advice if pain did not improve or if symptoms worsened. Mr Sartori suffered increasing chest pain on the 27 October 2019. An ambulance attended, but sadly, Mr Sartori did not respond to resuscitation efforts. No specific investigations were undertaken to rule out potentially lethal causes of the acute chest pain when Mr Sartori presented to A&E on the 24 October 2019. Had bilateral blood pressures and a CT scan been carried out on the 24 October 2019, it is likely that Mr Sartori's death would have been avoided.

4. **CIRCUMSTANCES OF THE DEATH**

As can be seen from the narrative conclusion, Paul Sartori sought emergency medical assistance for central chest pain on the 24th October 2019. The previous day he had begun to suffer from arm pain. On the morning of the 24th October 2019 he reported to the emergency operator that he had been suffering from clamminess and sweating, followed by numbness in his hand. On attendance of the paramedics at 0630, he had a pain score of 7 out of 10 and a raised heart rate of 107 and 108. The pain score reduced at 06:50 to 4 out of 10. The paramedics determined that he should be taken to A & E to investigate the cause of the chest pain.

Mr Sartori was taken to A & E where an A & E nurse took an incomplete set of observations and redirected Mr Sartori to the urgent care centre. There is no record of the A&E nurse's assessment.

In the urgent care centre, Mr Sartori was assessed by a GP who made a diagnosis of costochondritis.

Mr Sartori left the hospital without any further investigation or treatment. He continued to suffer from pain which became acutely worse on the morning of the 27th October 2019. At this time an ambulance was called but he was found to be unresponsive in his home address. Resuscitation efforts were provided but he was pronounced life extinct in his address on the 27th October 2019.

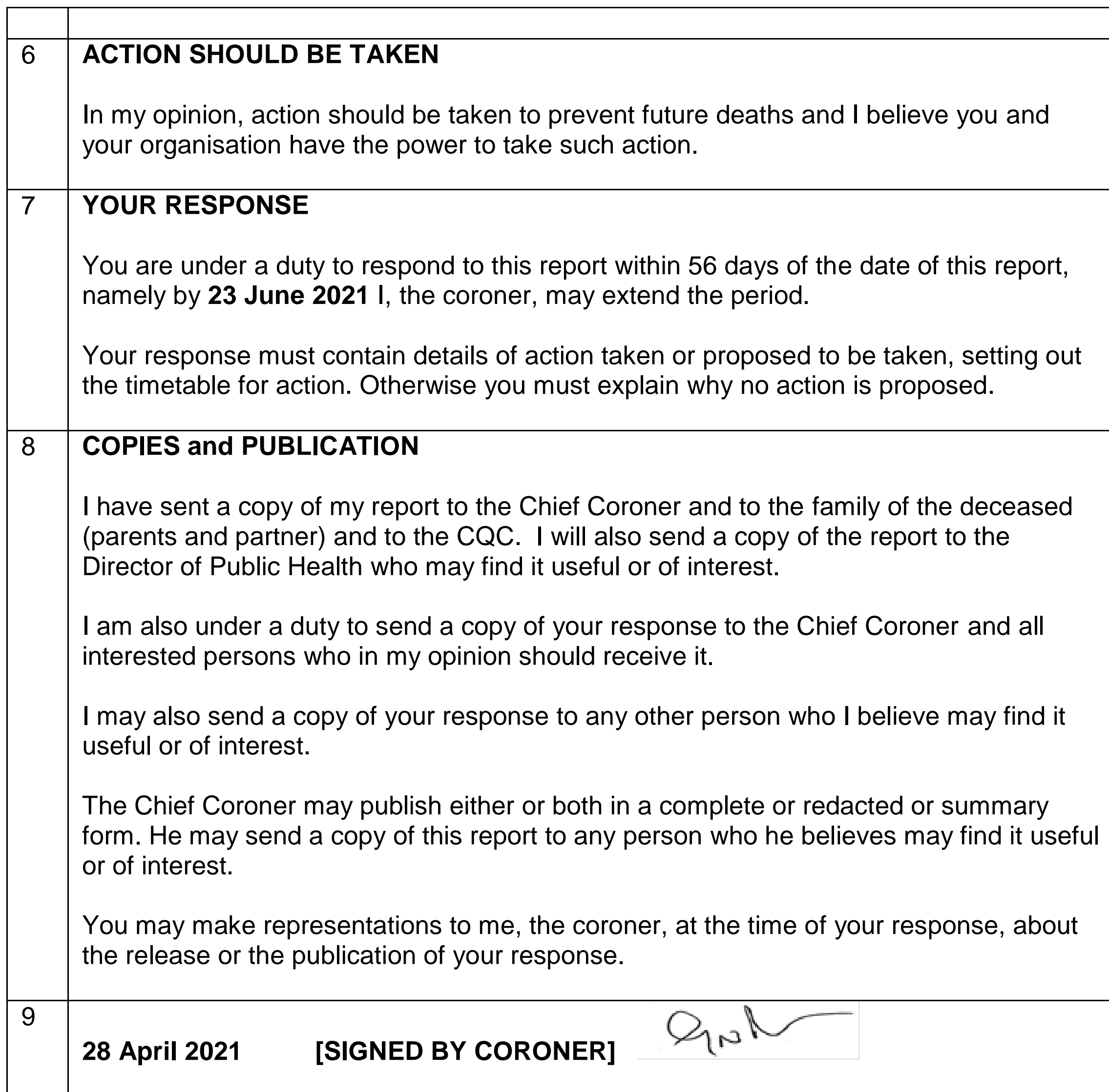
A post-mortem examination found that Mr Sartori had suffered a ruptured dissecting aortic aneurysm of the ascending thoracic aorta.

5 **<u>CORONER'S CONCERNS</u>**

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. The Inquest heard evidence that the streaming guidance in place for Barts Health A & E staff and NELFT staff had not been updated to take into account the learning from the death of Mr Sartori and to take into account the guidance from the THINK AORTA Campaign (launched in 2016).
2. The nurse making the decision to re-direct Mr Sartori from A&E did not record a full set of observations, to include a pain score, prior to diverting Mr Sartori from the A & E department. The nurse did not document her decision making process and rationale for redirecting Mr Sartori from A&E.
3. A junior sister who provided evidence at the Inquest was not aware of the THINK AORTA campaign. The Inquest heard that the senior leadership team had recently agreed to embed the THINK AORTA learning into practice at all levels within the emergency department. This learning had not been embedded at the time of the Inquest hearing.



6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe you and 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 **23 June 2021** 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 family of the deceased (parents and partner) and to the CQC. I will also send a copy of the report to the Director of Public Health who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. 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.
9	**28 April 2021 [SIGNED BY CORONER]**