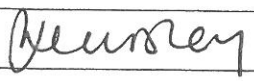
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Department Of Health, Richmond House** **79 Whitehall, London, SW1A 2NS**
1	**CORONER** I am Joanne Kearsley Area Coroner, for the Coroner area of South Manchester
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
3	**INVESTIGATION and INQUEST** On the 29th September 2015 I concluded the Inquest into the death of Nathaniel Luke Phillips born on the 18th May 1990 who died on the 15th April 2015 at Tameside General Hospital. The cause of death was confirmed as 1a) Hypoxic Brain Injury due to 1b) Acute Asthma Attack.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of Nathaniels' death are as follows: During the course of the Inquest the Court heard evidence from a number of witnesses including Nathaniels' Mother and also his General Practitioner. Nathaniel had been diagnosed with asthma as a child. He had a diagnosis of brittle asthma. For reasons which were unclear and which are currently being reviewed by his GP Nathaniel seems to have been lost to Adult Asthma Services once he was too old for the Paediatric services. He was last seen in his GP practice in April 2014. His last prescription for his asthma medication was issued in July 2014. In January and February 2015 Nathaniel presented twice to the emergency department following an acute exacerbation of his asthma. The Court heard that the reason Nathaniel did not collect any prescriptions for his asthma medication was because of the cost of the regular prescriptions. During this time he used inhalers which were prescribed to family members, several of whom were on the same medication. However the evidence from his GP confirmed that the lack of prescriptions issued meant that this indicated to them that Nathaniel was not requiring medication and that his asthma was therefore being controlled. It was confirmed that if the accurate situation had been known this may have led to an increase or

	alteration of his asthma medication. On the 13th April 2015 at 23.42 hours Nathaniel called an ambulance as he was having an acute exacerbation of his asthma. The Court heard his call to the ambulance service during which he was able to speak and provide all the requested information. As a result of the information provided the call was classed as requiring an ambulance within 20 minutes (according to local protocols). Unfortunately there were no ambulances available. At 00.13 hours Nathaniel makes a second call to the ambulance service, in this call his condition has clearly deteriorated. The Call handler from the ambulance service correctly increases the response code to a code red (requiring an ambulance within 7 minutes). Again there were no ambulances available and it was not until 00.22 that an ambulance was allocated. At this time, Nathaniels girlfriend arrives at the property and upon seeing Daniel speaks to the call handler who is still on an open telephone line and says that she is going to take Nathaniel in the car to the hospital. She is advised that an ambulance is now on its way but decides to take him. Whilst enroute Nathaniel collapses in the car. At hospital it is confirmed that he has suffered a severe lack of oxygen to his brain.
5	**CORONER'S CONCERNS** One of the concerns raised by the family and the GP was that a diagnosis of brittle asthma is not one of the illnesses covered by the medical exemption certificate, despite the fact that it is a life-threatening condition requiring medication. It was confirmed that illnesses such as diabetes and epilepsy which require continuous medication are covered. As indicated earlier due to the cost of his constant medication Nathaniel did not always collect regular prescriptions and relied on family members asthma medication. This meant his GP did not escalate his case or reassess his requirements and asthma control.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 **7 December 2015**. 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 following Interested Persons namely, **the family of Nathaniel Phillips.** I am also under a duty to send the Chief Coroner a copy of your response. 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.
9	**13.10.2015**  **Joanne Kearsley HM Area Coroner**