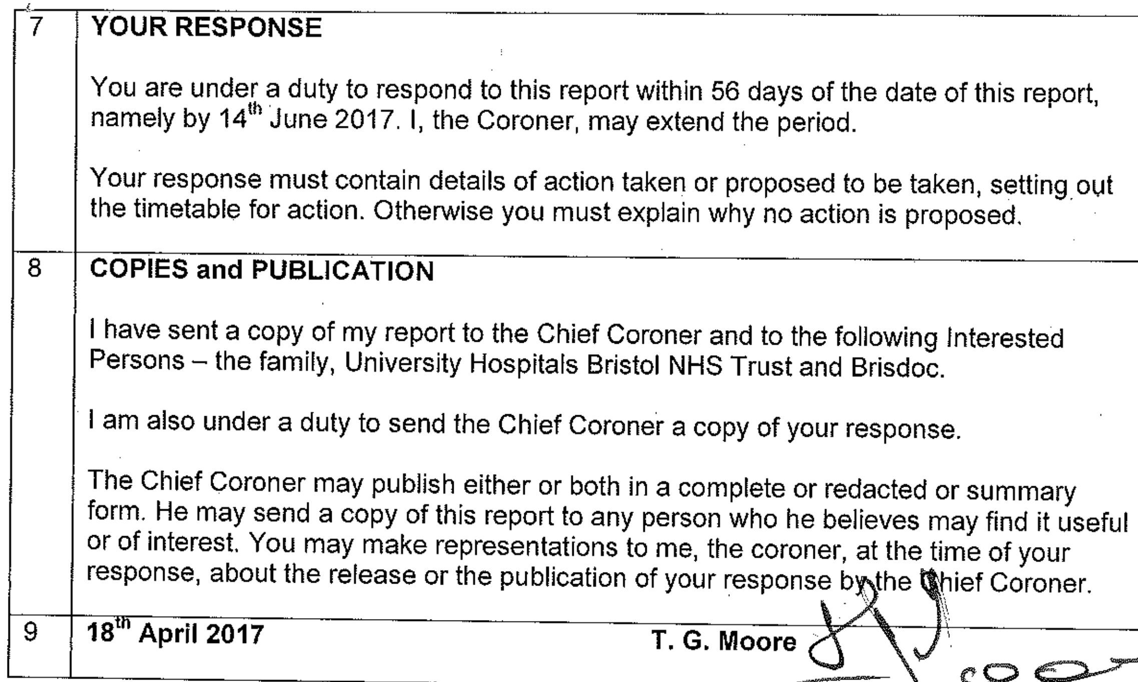
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. NHS**
1	**CORONER** I am Terence G. Moore, Assistant Coroner, for the area of Avon.
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 30th November 2016 an investigation commenced into the death of **David Lee BIRTWISTLE**, Aged **44**. The investigation concluded at the end of the inquest on 23rd March 2017. The conclusion was that the medical cause of death was I(a) Pulmonary embolism; I(b) Deep vein thrombosis and cardiomyopathy The conclusion as to the death was a narrative conclusion which read: **Mr. Birtwistle died of a pulmonary embolism having been diverted from an accident and emergency assessment two days prior to his death. This meant that further tests, which could have led to an earlier diagnosis of his condition, were not done.**
4	**CIRCUMSTANCES OF THE DEATH** **Mr. Birtwistle died of a pulmonary embolism having been diverted from an accident and emergency assessment two days prior to his death. This meant that further tests, which could have led to an earlier diagnosis of his condition, were not done.** **No 111 referral information was available to "front door" or the ED.**
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will 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. A national review of serious incidents and near misses in similar "front door" services should happen as a matter of some urgency in order to identify common themes that can inform future service design. 2. NHS 111 should share information with ED departments immediately. This needs to be in a user friendly format.
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 14th June 2017. 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 – the family, University Hospitals Bristol NHS Trust and Brisdoc. 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	**18th April 2017** **T. G. Moore**