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.** The Right Honourable Jeremy Hunt MP, Secretary of State for Health, 2 Marsham Street, London SW1P 5DR.
1	**CORONER** I am Simon Nelson, HM Assistant Coroner for the Coroner Area of Manchester West.
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 18th January 2018 I commenced an Investigation into the death of Angela Marion Turner, 57 years, born on the 30th June 1960. The Investigation concluded at the end of the Inquest on the 6th June 2018. The medical cause of death was:- Ia Spontaneous subarachnoid haemorrhage Ib Ruptured intracranial aneurysm The conclusion of the Inquest was Anglea Marion Turner died of natural causes.
4	**CIRCUMSTANCES OF THE DEATH** On the afternoon of Saturday 30th December 2017 having complained of intense pain following a sudden onset headache the son of the deceased telephoned 111. His called remained unanswered for approximately 45 minutes. He was subsequently advised by his mother's GP Practice to attend the local Walk In Centre where, although appropriately triaged, her subsequent assessment proved suboptimal and she was inappropriately discharged home. On the 31st December 2017 at approximately 15:30 hours she was discovered collapsed at home. A subsequent CT scan confirmed a subarachnoid haemorrhage from which she died on 10.01.2018.

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. 1. Wholly inadequate response to the call made to NHS 111 on the afternoon of 30th December 2017.	
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe that 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 21 August 2018. 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:- 1. [redacted] (daughter), [redacted] 2. [redacted] (son), 16 [redacted] 3. The Chief Executive, Wrightington, Wigan and Leigh NHS FT, Suite 2, Buckingham Row, Brick Kiln Lane, Wigan 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	**Dated** **26 June 2018**	**Signed** **Simon Nelson, HM Assistant Coroner, Manchester West**