REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] NHS 111 Team NHS England Skipton House 80, London Rd London SE1 6LH Mr Daniel Elkeles, Chief Executive for NW Collaborative Group CCGs [redacted]
1	**CORONER** I am Dr Fiona Wilcox, Senior Coroner, for the coroner area of Inner West 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.
3	**INVESTIGATION and INQUEST** On 19th June 2013, I commenced an investigation into the death of Ms Samia Yasmin Shara aged 15years. The investigation concluded at the end of the inquest on 27th November 2014. The conclusion of the inquest was: Medical Cause of Death 1 (a) **Acute Heart Failure** (b) **Aneurysm of Aortic Sinus and Ruptured Cusp of Aortic Valve.** How, when and where and in what circumstances the deceased came by her death: ***Samia Shara suffered form an undiagnosed congenital heart problem. From around early April 2013 Samia began to experience intermittent shortness of breath and palpitations. She was seen in general practice and referred to cardiology. However before she was seen she suffered a rare acute complication of her heart problem which led to and caused her death.***

	Conclusion of the Coroner as to the death ***Natural Causes***
4	**CIRCUMSTANCES OF THE DEATH** It was clear from the evidence taken during the inquest that she suffered an acute rupture of one of the cusps of her aortic valve causing her to go into crashing heart failure. Her brother attempting to seek urgent medical advice on her behalf and made calls to 999 and 111. For various reasons she was not recognised by the call takers to be as unwell as she was until the final call to 999 such that the provision of emergency LAS services were delayed. This delay was not causative in her death on the balance of probabilities, but various incidents occurred, such as the downgrading of the call by a call taker and a failure to re-triage when the brother called back by a call taker.
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) That long and complex calls made to 999 and 111 should be available for audit by the CCG to identify learning opportunities and thus improve outcomes via a quality assurance process. (2) That call takers should not be able to downgrade a call by moving to a pathway of lower acuity.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR 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 13th February 2014. 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 : [redacted] Flat 54, Dartington House, Senior Street, London. W2 5TE.

	[redacted] Call Handler, London Central and West, Unscheduled Care Collaborative, Exmoor Street, London. W10 6DX [redacted] Call Handler, London Central and West, Unscheduled Care Collaborative, Exmoor Street, London. W10 6DX I have also sent it to the following persons or organisations who may find it useful or of interest: [redacted] 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	**19th December 2014.** **Dr Fiona Wilcox,** **HM Senior Coroner,** **Inner West London,** **Westminster Coroner's Court,** **65, Horseferry Road,** **London.** **SW1P 2ED.**