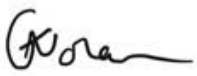
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Medical Director, Totally Urgent Care (incorporating Vocare)**
1	**CORONER** I am Georgina Nolan, Senior Coroner for the coroner area of Newcastle and North Tyneside.
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 5th October 2022 I commenced an investigation into the death of Carol Leeming, aged 77. The investigation concluded at the end of the inquest on 20th September 2023. The conclusion of the inquest was natural causes, the medical cause of death being 1a) Coronary artery atheroma; 2) Chronic Obstructive Pulmonary Disease.
4	**CIRCUMSTANCES OF THE DEATH** Carol had a number of medical conditions. In the months prior to her death she had repeatedly sought advice from her GP. On the afternoon of the day prior to her death Carol rang for an ambulance requesting help and describing having a racing heart. She requested admission to hospital. Her call was triaged for a call back by the out of hours GP service provided by Vocare. The call was returned that evening by a GP working for Vocare. The GP believed that he had requested an ambulance for Carol via an electronic system but there was no such facility and an ambulance was not requested. The GP was unfamiliar with the systems in place. He had recently started working for Vocare and had not completed induction training.
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 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) There was no requirement for the out of hours GP to have completed induction training prior to starting work for Vocare; (2) There was no facility for online induction training to be made available to new joiners who were unable to attend in person induction training; (3) There was evidence of confusion amongst staff about the functioning and capabilities of the systems in place at the call centre; and (4) Evidence was given at the inquest that there was a regular turnover of different GPs working for Vocare for short periods as part of their training.
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, namely by 21st November 2023. 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: Mrs Leeming's family, Totally Urgent Care (incorporating Vocare), NEAS, and Medical Protection Society. 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	**[DATE]** **[SIGNED BY CORONER]**  **25th September 2023**