REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: NHS England
1	CORONER I am Alison Mutch, HM Senior 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 18th April 2023 I commenced an investigation into the death of Kirsty Michelle Hendry. The investigation concluded on the 8th September 2023 and the conclusion was one of **Narrative: Died from the complications of a subarachnoid haemorrhage caused by a burst aneurysm which was not diagnosed until vasospasms had severely compromised her neurological status and she could not be successfully treated.** The medical cause of death was **1a) Cerebral Infarction; 1b) Vasospasm; 1c) Spontaneous Subarachnoid Haemorrhage**
4	CIRCUMSTANCES OF THE DEATH On 30th March 2023 Kirsty Michelle Hendry was seen at her surgery by an advanced nurse practitioner. She presented with a headache and vomiting which had started two days previously. She was prescribed antibiotics for a suspected infection. It is probable that the symptoms were due to a subarachnoid haemorrhage due to a burst aneurysm. A hospital referral at this point would probably have identified the subarachnoid haemorrhage and allowed preventative treatment to reduce the risk of her developing severe vasospasm. On 2nd April 2023 an ambulance was called as she was feeling unwell. The ambulance crew did not recognise that her behaviour was inconsistent with her usual presentation. She was taken to Tameside General Hospital where there was a prolonged wait to be seen. A CT scan undertaken showed evidence of a subarachnoid haemorrhage that had occurred previously around 28th March 2023. The scan was incorrectly reported as being clear. At Tameside General Hospital her consciousness levels were reduced, and she was agitated. She had probably developed a severe vasospasm from the subarachnoid haemorrhage. Treatment options at this point are extremely limited. An MRI scan on 5th April 2023 showed multi territorial infarctions and significant narrowing of all the intracranial vessels. On the balance of

	probabilities, the neurological situation was probably irreversible on her admission to Tameside General Hospital. She was transferred to Salford Royal Hospital where attempts to treat her were unsuccessful. She died at Salford Royal Hospital on 11th April 2023.
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. – The inquest heard evidence that early identification of a burst aneurysm is vital if treatment is to be offered at an early enough stage to reduce the risk of death. The inquest was told that particularly in primary care the symptoms are not readily understood and awareness is often low. In Kirsty Hendry's case she had the key symptoms that are linked to a burst aneurysm. The evidence was that it was important awareness be raised so that all doctors and other health professionals carrying out examinations in a primary care setting should understand the key symptoms /presentation of a burst aneurysm so that appropriate referrals could be made to secondary care and CT scans be undertaken at an early stage when the probable could be easily identified and treatment options were available.
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 15th December 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 namely 1) [redacted] on behalf of the Family and; 2) Tameside and Glossop Integrated Care NHS Foundation Trust, who may find it useful or of interest. 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	**Alison Mutch** **HM Senior Coroner**  **20.10.2023**