REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **The Rt Hon Steve Barclay Secretary of State for Health** 2. **The Rt Hon Michael Gove, secretary of State for Levelling up, Housing and Communities**
	CORONER I am Joanne Kearsley, Senior Coroner for the Coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On the 16th February 2023, I commenced an investigation into the death of Luke Matthew Brooks, date of birth 17th November 1994 who died on the 25th October 2022 at his home address [redacted] Street, Oldham. The medical cause of her death was confirmed as 1a) Acute respiratory distress syndrome due to 1b) Aspergillus Pneumonia.
4	**CIRCUMSTANCES OF DEATH** Luke died unexpectedly at his home address. He had been unwell with cold/flu like symptoms for approximately one week. Luke lived at his home address together with his parents, brother, cousin and another family friend. The property was rented from a private landlord. The family had lived in the property since 2014. Over the years they had numerous concerns as to the condition of the property which was cold and damp. In 2021 concerns had been raised to both the landlord and the environmental health department at Oldham Council by both the family and an early help service Positive steps. Whilst the Inquest considered whether the aspergillus (fungi/mould) was linked to the property the evidence did not support this. The source of the aspergillus could not be determined. Over the weekend prior to Lukes death he had had several discussions with out of hours medical providers via the NHS 111 call line. This is a commissioned service run by North West Ambulance ("NWAS"). Whilst the outcome of the calls had on two occasions suggested that Luke required a category three ambulance (attendance to be within 2 hours) the court heard over the weekend the wait time was 6-8 hours. Luke declined the same. On one occasion Luke did ask whether he could take himself to A&E but was advised not to. This was in line with a local NWAS policy that people who had described chest pain should not make their own way to A&E.
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. There is no register of Private landlords available in England. The court heard this was outwith other countries within the UK who had a national register. The lack of this meant that Local authorities could be hampered in not knowing up to date address/contact details when they were made aware of concerns with a privately rented property. This is particularly important when the issue is one which is potentially life threatening ie asbestos in a property, dangerous items such as inappropriate cord blinds in a property with children or excessive damp. 2. NWAS had a local policy of advising people who described symptoms of chest pain (not immediate life threatening) to not attend A&E on their own. Whilst NWAS have now revised this policy to remove this, it is not known if this could be set out in the local policies of other ambulance services.
W	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 12th October 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:- The family of Luke Brooks Oldham Borough Council North West Ambulance Service 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 from. 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 17th August 2023 Signed: