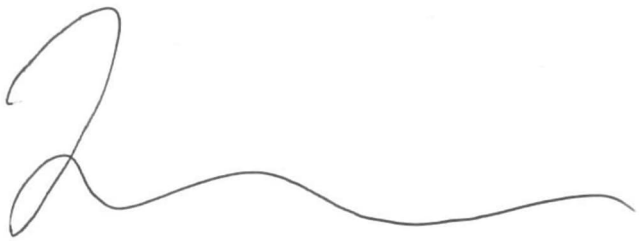
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 BARDOC** **2 [redacted], Secretary of State for Health and Social Care**
1	**CORONER** I am John Stanley POLLARD, 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 21 March 2024 I commenced an investigation into the death of Andrew Dominic HEYS aged 29. The investigation concluded at the end of the inquest on 08 January 2025. The conclusion of the inquest was 'Open' and the medical cause of death was established as Ia) Drowning II) Post-Vaccination Auto-Immune Encephalopathy.
4	**CIRCUMSTANCES OF THE DEATH** In December 2021 the deceased received the vaccination against Covid 19. This was his booster. He reacted very badly to the vaccination and thereafter suffered from Auto-Immune Encephalopathy, the effects of which were devastating both physically and mentally. On the 12th March 2024 the deceased went to a bridge over the Manchester Ship Canal, climbed over the parapet and fell into the water. His body was discovered four days later.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: During the course of the evidence, the GP, who was acting on behalf of BARDOC, the out of hours provider, indicated to me that she had never been trained by BARDOC, in how to follow their 'pathways'; this meant that she 'closed' the call alter speaking to the patient, rather than returning it to the Ambulance Service as should have happened. She was also confused about how she could access the patient's own GP records; again, she said she had not had any training in this regard. During the course of the evidence, I heard, yet again, the common complaint that one health professional is unable to access the health records of the patient held by another health professional. In this case, the manager of the 111 Helpline agreed that the various IT systems do not "talk to each other". It is of concern to me as to why all bona fide health professionals cannot have access to all health data held anywhere within the NHS.

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 March 14, 2025. 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] [redacted] **North West Ambulance Service** I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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: 24/01/2025**  **John Stanley POLLARD** **Assistant Coroner for** **Manchester West**