REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], President of The Royal College of Radiologists, The Royal College of Radiologists 63 Lincoln's Inn Fields London WC2A 3JW [redacted] [redacted], President of The Royal College of Surgeons, 38-43 Lincoln's Inn Fields, London WC2A 3PE [redacted] [redacted] President of The Royal College of Phyisicians Royal College of Physicians 11 St Andrews Place Regent's Park London NW1 4LE [redacted]
1	**CORONER** I am R Brittain, Assistant Coroner for Coventry.
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	**INVESTIGATIONS and INQUESTS** An investigation into the death of Man Yin 'Anita' Ng (date of birth 1/8/73) was opened, following her death on 22/1/25. An inquest was opened on 17/7/25 and concluded on 28/11/25. A narrative conclusion was reached as follows (further detail can be found in section 4): Anita Ng died from a re-rupture of an intracranial vascular aneurysm, shortly prior to intended treatment to reduce this risk. There were intervals to her receiving this treatment, such that this was planned to occur outside of the intended window. It is difficult to determine the consequence of these intervals, as re-rupture can occur owing to other factors. As such, it has not been possible to conclude that these intervals contributed to or caused her death.
4	**CIRCUMSTANCES OF THE DEATH**

	Anita attended hospital on 19/1/25 after developing a severe headache and neck stiffness at around 10pm on the evening before. She was seen by a doctor 9 hours after presenting to the Emergency Department. A CT scan confirmed the presence of a subarachnoid haemorrhage, arising from an aneurysm, as confirmed by a CT angiogram undertaken on 20/1/25. A plan was initiated to deploy coils within 48 hours of symptom onset, in order to reduce the risk of re-rupturing. However, the neurointerventional catheter lab (where this procedure is undertaken) was not available, owing to the need to perform three consecutive thrombectomy procedures, over the course of the 20/1/25. As such, a plan was made to undertake the procedure the following day, when coiling would not ordinarily be undertaken. However, staff made themselves available and the intention was to utilise the anesthetist who would have otherwise been covering potential thrombectomy cases. Unbeknownst to the neurosurgical and neurointerventional radiology teams, the anaesthetist had been allocated to the trauma list and was therefore not available on the morning of the 21/1/25. An anaesthetist was taken off an elective case and made available for the afternoon of 21/1/25. Sadly, shortly before the coiling procedure was due to be commenced, Anita suffered a re-rupture of her aneurysm and died as a consequence of this on 22/1/25.
5	**<u>CORONER'S CONCERNS</u>** During the course of this 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 **MATTER OF CONCERN** following the inquest into Anita's death is as follows: I am concerned that the processes surrounding the treatment of subarachnoid haemorrhages, arising from aneurysms, are complex and not as streamlined as compared to other treatments. There is clearly variation in the availability of neurointerventional procedures. This is a nationwide resource issue, which I heard has been recognised and that steps are being taken to address. The specific concern which arises from Anita's death relates to which clinical team is best placed to have overall responsibility for such patients. I heard that, traditionally, neurosurgeons would treat these cases but that, increasingly, ruptured aneurysms are treated by interventional radiologists, with input from the neurosurgery team limited to initial referral, investigation and post-procedural care. However, Anita's case demonstrates the complexities of this arrangement, which I heard contrasts with the change in practice that has occurred in the treatment of patients who have suffered strokes and also cardiac patients treated by interventional cardiologists (when previously they would have been under the care of cardiothoracic surgeons). I heard evidence that interventional radiologists do not have admitting rights, which would allow them to have patients admitted to hospital wards and that, as such, patients like Anita would come under the care of the neurosurgical team. I am concerned that this complex arrangement does not reflect the current management of such patients and places them at risk. Whilst the circumstances in which Anita died were unusual, my concern relates to the overarching manner in which this condition is managed, particularly when compared to thrombectomies.

	I heard evidence that the Royal College of Radiologists would be best placed to respond to such concerns but, on reflection, my view is that this is a complex issue which warrants input from the three Royal Colleges that could provide guidance as to which clinical teams would best manage patients with this condition.
6	**ACTION COULD BE TAKEN** In my opinion action could be taken to prevent future deaths and I believe that the addressees 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 30 January 2026. 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, the Ng family, the hospital Trust, NHS England, the Department of Health and Social Care and the CQC. 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. She may send a copy of this report to any person who she 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	5 December 2025  **Assistant Coroner R Brittain**