## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**The Rt Hon Jeremy Hunt MP, Secretary of State for Health, Department of Health, Richmond House, 79 Whitehall, London.** |
| 1 | **CORONER**<br><br>I am R Brittain, Assistant Coroner for Inner London North. |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>Stephen Leven died, aged 56, on 13 December 2016 from an intracerebral haemorrhage. The inquest into his death concluded on 10 May 2017; I recorded a conclusion of natural causes. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Mr Leven had a significant past medical history of haemophilia for which he had been undergoing treatment at the Royal Free Hospital. He carried with him a card provided by this hospital, which set out the diagnosis and was intended to be presented to healthcare providers to inform them of the potential significance of the disease, as it related to other medical conditions.<br><br>I heard from Mr Leven's partner that she was not aware of his haemophilia diagnosis, despite having lived with him for a number of years.<br><br>In early December 2016 Mr Leven developed a headache and changes to his visual field. On 7 December he presented to an optician who confirmed that there was a deficiency in his visual field and recommended that he present urgently to his GP for onward referral. Instead Mr Leven attended A&E that evening. He did not disclose to the A&E department his haemophilia diagnosis, nor did the clinicians there have access to GP information that would have contained information regarding this diagnosis.<br><br>CT scanning demonstrated a large intracerebral haemorrhage and, after a deterioration which resulted in him being intubated and ventilated, he was transferred to a neurosurgical centre. I heard evidence from the neurosurgical consultant who treated Mr Leven that they also did not have access to GP records.<br><br>Mr Leven underwent a neurosurgical procedure to treat the brain haemorrhage. As this procedure was finishing, information was provided by members of Mr Leven's family that he had haemophilia. Appropriate treatment was provided but, unfortunately, he did not recover substantively. He died on 13 December 2016. |

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| | I heard evidence from the treating neurosurgeon that the fact Mr Leven did not disclose his haemophilia diagnosis did not cause or contribute to his death. This is one of the reasons I concluded that his death arose from natural causes.<br><br>However, I was concerned that the treating clinicians did not have access to GP records which recorded the diagnosis of haemophilia. This is related to an issue I raised with the Department of Health in October 2015 (see attached report). The response (see attached) set out that access to the 'Summary Care Record' (SCR) was due to be implemented for 'hospital acute admissions' by March 2016. The response also stated that the provision of 'enhanced summary care records' was being developed, which would allow access to 'special patient notes'. |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows:<br><br>I am concerned that, in different circumstances, the lack of access to GP information regarding Mr Leven's diagnosis of haemophilia, could have caused or contributed to his death. As such, I am concerned that deaths could occur in future similar circumstances if further action is not taken to facilitate secondary care access to GP records. |
| 6 | **ACTION COULD BE TAKEN**<br><br>In my opinion action could be taken to prevent future deaths and I believe that the addressee, has the power to take or may be actively undertaking such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 10 July 2017. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner, Mr Leven's family, Royal Free Hospital, North Middlesex Hospital and the National Hospital for Neurology and Neurosurgery.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **15 May 2017** |

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| |  <br>**Assistant Coroner R Brittain** |