REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: 1. [redacted]: Director, Alcohol, Drugs & Tobacco, Health and Wellbeing Directorate, Public Health England - Wellington House, 133-155 Waterloo Road, London. SE1 8UG 2. [redacted], National Medical Director, NHS England - Skipton House, 80 London Road, London SE1 6LH
1	CORONER I am R Brittain, Assistant Coroner for Inner London North.
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 [redacted] died on 13 June 2019, aged 30 years, from the consequences of cocaine use, which resulted in a posterior stroke. I heard the inquest into his death on 22 November 2019 and recorded a narrative conclusion, as set out below: [redacted] *died from the consequences of cocaine use, which resulted in a posterior stroke. There were intervals to the treatment of this, although it is not possible to conclude that this contributed to his death.*
4	CIRCUMSTANCES OF THE DEATH [redacted] was admitted to Queen's Hospital, Romford on 9 June 2019. The previous evening he had ingested cocaine and, in the early hours of 9th, he collapsed, unable to speak or move his left side. He was diagnosed with a basilar artery occlusion and underwent thrombolysis at 14.40 later that day. He was transferred to The National Hospital for Neurology and Neurosurgery shortly thereafter. A thrombectomy procedure was successfully carried out, also on 9 June. However, he suffered a further deterioration and was declared brainstem dead on 13 June 2019.
5	CORONER'S CONCERNS 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 MATTERS OF CONCERN following the inquest were as follows: Concern 1, to be addressed by Public Health England 1. [redacted] family raised concerns that the risk of stroke arising from cocaine use was not known to him nor his family members. They were concerned that future deaths could occur in similar circumstances and that there is limited public awareness of such risks. I share these concerns and ask that Public Health England consider this point. Concern 2, to be addressed by NHS England 2. I heard evidence during this inquest that the availability of thrombectomy is currently variable and dependent on geographical location and timing. I am concerned that this variation will mean that future deaths will occur in similar circumstances, unless access to thrombectomy services is improved.
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 1 May 2019. 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, [redacted], Barking, Havering and Redbridge University Hospitals NHS Trust and University College London Hospitals NHS Foundation Trust. I am also under a duty to send the Chief Coroner a copy of your responses. 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	Assistant Coroner R Brittain 6 March 2020