## Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

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| | **REGULATION 28 REPORT TO PREVENT DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1 Dalton Surgery**<br>**2 CQC North**<br>**3 NHS England (Reg 28 Reports)** |
| **1** | **CORONER**<br><br>I am Crispin OLIVER, HM Assistant Coroner for the coroner area of West Yorkshire Western Coroner Area |
| **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>On 03 May 2023 I commenced an investigation into the death of Myles Edward SCRIVEN aged 31. The investigation concluded at the end of the inquest on 11 July 2025. The conclusion of the inquest was that:<br>Myles Edward Scriven died a natural death to which neglect contributed. |
| **4** | **CIRCUMSTANCES OF THE DEATH**<br><br>Myles Edward Scriven died at Huddersfield Royal Infirmary on 16 April 2023. Contributing to the cause of his death was lack of adjustments for his Autism and Learning Disabilities resulting in incorrect decision making as to his care and medication. |
| **5** | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows:<br>(brief summary of matters of concern)<br><br>While the rider of Neglect does not attach to the actions of the Dalton Surgery, the fact remains that between 16 and 20 March 2023 Myles had several contacts with the Dalton Surgery while he was suffering with an on going Pulmonary Embolism. Non of these resulted in a referral to secondary care. The combined evidence of three expert witnesses was that the manner in which his care was handled at this stage contributed to his death. The following are concerns that I have arising from the evidence in he Inquest.<br>1. Ignorance of what was required for Myles in the circumstances of his Learning Disability and Autism - the GPs clearly only had a superficial grasp of the regulatory requirements and realities to do with Learning Disabilities. They are clearly well intentioned and caring but their appreciation and approach seems to have been based entirely on professional experience and good intentions rather than real knowledge of what was required and how to implement it.<br>Notably:<br>•They repeatedly used the words learning difficulties and learning disabilities |

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| | interchangeably and apparently randomly – I am not told that Myles had a personal preference about which to use that they deferred to. Essentially, they seem to have been ignorant as to the distinction.<br>•They made only the most modest adjustments for Myles's Learning Disabilities and Autism.<br>•They clearly had very little grasp of what the Learning Disabilities Register was and how it worked. Neither of the GPs who gave evidence were able to provide a solid, reliable, version of how it operated in their practice, when or/if Myles had been entered on to it, whether it was distinct from the psychiatric review - one seemed to conflate the two and the other said that it was something managed by a Nurse in the practice. It is quite evident that correspondence was coming in from Learning Disabilities Psychiatry but nothing at all from Social Services. This is not something that seems to have triggered any particular reaction at the GP level. They seemed to operate on the basis that the Learning Disabilities 'box had been ticked' and that nothing further was needed. In fact, Myles seems to have been on the Register from 2020 but by the 20 October 2022 when he had been at hospital in relation to his PE he had no Learning Disability Social Worker and concomitantly no VIP passport on admission to hospital . The GPs clearly had no idea of how important all this was. I heard evidence from a secondary care Learning Disabilities Professional that they, in secondary care, rely a great deal on primary care to get these things sorted out. Here, nothing went back from the Practice to the Learning Disabilities Service to chase these things.<br>2. The failure of the GP to record numeric observations properly on 20 March 2023.<br>3. The failure of the Dalton Surgery to undertake any rigorous and detailed internal review for learning purposes after this incident. |
| **6** | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by September 08, 2025. 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 and to the following Interested Persons<br><br>[redacted]<br><br>I have also sent it to<br><br>who may find it useful or of interest.<br><br>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.<br><br>I may also send a copy of your response to any person who I believe may find it useful or of interest.<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.<br><br>You may make representations to me, the coroner, at the time of your response about the |

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| | release or the publication of your response by the Chief Coroner. |
| **9** | **Dated: 14/07/2025**<br><br>  <br><br>**Crispin OLIVER**<br>**HM Assistant Coroner for**<br>**West Yorkshire Western Coroner Area** |