

**REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS
2013**

1.	CORONER I am Richard Brittain, Assistant Coroner, for the coroner area of Inner London North.
2.	DATE OF REPORT 9 July 2026 (this is an amended report sent initially on 11 May to recipients 1 and 2 and to recipient 3 on 9 July 2026)
3.	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.	THIS REPORT IS BEING SENT TO 1. The chair of the British Viral Hepatitis Group, British Association for the Study of the Liver (BASL) [REDACTED] 2. Director of Public Health Programmes, UK Health Security Agency (UKHSA) [REDACTED] 3. Director of Specialised Commissioning, NHS England You are under a duty to respond to this report within 56 days of the date of this report, namely by 3 September 2026. I, the coroner, may extend the period if an appropriate application is made.
4.	YOUR RESPONSE 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
5.	SUMMARY OF CORONER'S CONCERN Having heard evidence relating to Mr Tran's death, I am concerned that:

	1. There is a lack of national guidance regarding which services should be responsible for the monitoring and prescribing in relation to hepatitis B reactivation prevention; 2. There is a large population of patients who are found to have hepatitis B infection through opt-out screening in Emergency Departments but there is a lack of specialised commissioning to maintain subsequent engagement with services. I heard that this differs from the position with regards to hepatitis C and HIV services, even though these patient populations are smaller.
6.	ACTION SHOULD BE TAKEN In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
7.	INVESTIGATION AND INQUEST On 2/10/25, an investigation was commenced into the death of Tung Thanh Tran, aged 41 years. I heard the subsequent inquest on 13/3/26. The medical cause of death was determined to be: 1.a. Acute liver failure 1.b. Sepsis (unknown source) 1.c. Hepatitis B reactivation owing to cessation of medication 2. Immunosuppression for renal transplantation Mr Tran died at Royal Free Hospital, London on 12/9/25 Inquest Conclusion Mr Tran died of complications arising from reactivation of a viral illness, which arose from inadvertent discontinuation of necessary medical treatment.
8.	CIRCUMSTANCES OF DEATH Mr Tran had a background history of renal transplant in 2013 and was diagnosed with chronic hepatitis B as part of this process. After a period of disengagement from services, Mr Tran was discharged from hepatology but continued to receive viral reactivation prophylaxis (Entecavir) from renal transplant services. Supply of medication changed to home delivery in early 2025 but the Entecavir was inadvertently discontinued, as there was a presumption that hepatology would continue to prescribe this. Mr Tran appears to have understood this to have been an intentional change of his medication. He attended his local hospital in August 2025 with signs of acute liver disease from reactivation of hepatitis B and was transferred to the Royal Free Hospital. He was too unwell to be considered for liver transplant and sadly died on 12 September 2025.

9.	CORONER'S CONCERNS During the course of the inquest I heard evidence 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: 1. There is a lack of national guidance regarding which services should be responsible for the monitoring and prescribing in relation to hepatitis B reactivation prevention; (concern directed to BASL) 2. There is a large population of patients who are found to have hepatitis B infection through opt-out screening in Emergency Departments but there is a lack of specialised commissioning to maintain subsequent engagement with services. I heard that this differs from the position with regards to hepatitis C and HIV services, even though these patient populations are smaller (concern directed to UKHSA and subsequently NHE England after initial input from UKHSA)
10.	COPIES AND PUBLICATION OF THIS REPORT I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: 1. Mr Tran's family 2. The Royal Free Hospital I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
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