	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] Hon. Secretary of the Royal College of General Practitioners Royal College of General Practioners 30 Euston Square London NW1 2FB 2. [redacted] **President,** British Cardiovascular Society 9 Fitzroy Square, London, W1T 5HW
1	**CORONER** I am Andrew Harris, Senior Coroner, London Inner South
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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 12.10.11 I opened an inquest into the death of Amna Umer Ahmed, aged 30, dod 10th October 2011, case ref 02631-2011. The inquest was heard on 18th September 2013. The conclusion of the inquest was natural causes.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Ahmed, aged 30, with a family history of heart disease, was seen by ambulance staff with chest pain and examination and ECG were reported as normal. The officers were aware of and considered sudden adult death syndrome. She needed medical assessment and chose to go later to her GP for further investigation. He concluded that the pain was non cardiac, but referred her for an appointment in a chest pain clinic. She died sudden adult cardiac death syndrome (SAD) a few hours later at home.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. The GP had not considered the possibility of sudden adult cardiac death syndrome, which is rare but afflicts young people and may be inherited. The mechanism of death is often an arrhythmia, which is difficult to diagnose but a specialist needs to examine the QT interval on the ECG and a 24 tape is often indicated. He did not order a Troponin test or full ECG or refer urgently to hospital and did not know under what circumstances he should do so. He knew of no guidance available to GPs. In my opinion there is a risk that future deaths will occur unless action is taken to increase awareness of this condition and the circumstances in which young people with chest pain or dizziness should be urgently referred. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – (1) Possibility of generally low awareness of the condition of SAD in general practice (2) Apparent lack of guidelines or lack of awareness of guidelines available to guide GPs on the circumstances for urgent referral of patients who should be suspected as being

	vulnerable to SAD.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe the Royal College of Practitioners, if appropriate in conjunction with the British Cardiovascular Society, 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 November 19th 2013. 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 and to the following Interested Persons: [redacted] [redacted]Ferryview Health Centre I have also sent it to LAS who may find it useful or of interest. 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. 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. [redacted]
9	**[DATE]** 25 September 2013 **[SIGNED BY CORONER]**