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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br>**Re Yaser Saleh, case ref 02233-2012**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>1. Mr Christopher Spencer, Chief Executive Officer, EMIS, Rawdon House, Yeadon, Leeds LS19 7BY<br><br>2. The Secretary of State for Health, Rt. Hon Jeremy Hunt, Richmond House, 79 Whitehall, London SW1 2NS<br><br>3. [redacted] Iveagh Surgery Akerman Health Centre, 60 Patmos Road, London SW9 6AF |
| 1 | **CORONER**<br><br>I am Dr Andrew Harris, Senior Coroner, London Inner South |
| 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 | **INQUEST**<br><br>On 17th September, 2012, I opened an inquest into the death of:<br>**Yaser Saleh, aged 15 years, died 13.09.12**<br><br>I concluded the inquest at a full hearing on 145h October 2014.<br>The medical cause of death was Acute Asthma. The boy collapsed with an arrest. The conclusion as to the death was natural causes. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Master Saleh was registered with a general medical practice in London. Evidence from a consultant physician and ambulance service senior paramedic was that cardio-respiratory arrest from acute asthma may occur very suddenly and is, as here, is refractory to resuscitation. To prevent such deaths appropriate treatment must be given and medical advice sought earlier in an exacerbation. A respiratory nurse gave evidence that the National Report on Asthma Deaths identified under use of steroids as a key cause of avoidable deaths and identified that electronic surveillance was needed of those not getting steroids, who need them.<br><br>This boy received regular steroid inhalers in 2004 and presented to accident and emergency department in 2006 requiring restarting steroids. Between 2003 and 2009 he attended A&E 6 times with asthma and had 3 non attendances at respiratory clinics. We know that the family regularly visit Saudi Arabia and so that there availability for monitoring and prescribing was not continuous. His general practice last prescribed for him in September 2008, and the attendance at A&E with uncontrolled asthma in 2009 did not trigger a GP review, as it would under today's arrangements. |
| 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. |

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| | The **MATTER OF CONCERN** is as follows. –<br><br>The GP reported that she believes that her EMIS computer system only called up people for review who were receiving regular prescriptions and thus a patient who had been on regular treatment but no longer was asking for inhalers was not identified as requiring call up for review. Whilst the court heard it was possible to customize the QOF system to call up patients, there was, according to the GP, no computerised system of calling up asthmatics who needed review unless they were currently on regular medication. She and the consultant in emergency medicine considered this created a risk of preventable deaths, that merited my making this report. The consultant in emergency medicine also said that this risk applied to other chronic diseases, such as epilepsy.<br><br>This risk of not identifying those at risk of death because they no longer comply or have not rebegun necessary treatment *taken in the past* is brought to the attention of EMIS and the Secretary of State, to consider whether EMIS has the potential or another electronic system should be commissioned to ensure that those with chronic disease requiring review and monitoring, are triggered for the attention of the GP, on wider criteria than current prescribing, or if such a system is available that [redacted] considers using it and other GPs are made aware of its use. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe that EMIS, [redacted] and/or Secretary of State may have or know who has the power to take such decisions. |
| 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 Friday 12th December 2014. 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.<br><br>If you require any further information or assistance about the case, please contact the case officer, [redacted] |
| 8 | **COPIES and PUBLICATION**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: [redacted] (father), [redacted] (brother), [redacted] London Ambulance Service and [redacted] Kings College Hospital. I am also sending this report [redacted] Consultant in Emergency Medicine KCH and [redacted] Senior Paediatric Respiratory Specialist Nurse KCH (witnesses) and to the Royal College of General Practitioners and the British Thoracic Society.<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 | **[DATE]** 17th October 2014 **[SIGNED BY CORONER]** |