Her Majesty's Coroner for the
Northern District of Greater London
(Harrow, Brent, Barnet, Haringey and Enfield)

North London Coroners Court,
29 Wood Street,
Barnet EN5 4BE

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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Northwick Park Hospital** Watford Road, Harrow, Middlesex, HA1 3UJ 2. **Department of Health** Department of Health Richmond House 79 Whitehall London SW1A 2NS
1	**CORONER** I am Andrew Walker, senior coroner, for the coroner area of Northern District of Greater London
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** On the 12 July 2012 I opened an inquest touching the death of Mone Jahni Karl White, aged 3 years old. The investigation concluded at the end of the inquest on the 17th January 2014. The conclusion of the inquest was "Narrative verdict", the medical case of death was ;1a Acute heart failure, 1b Asthma/ chest infection, and under paragraph 2 Dilated cardiomyopathy.
4	**CIRCUMSTANCES OF THE DEATH** Mone suffered with dilated cardiomyopathy, probably caused by a viral infection. Mone was under the care of the Royal Brompton hospital and had repeated episodes of illness requiring hospital treatment precipitated by infections. The Royal Brompton Hospital had in 2010 produces a document giving guidance to those who may come into contact with Mone. A copy was sent to Northwick Park Hospital and the London Ambulance Service and Mone's parents had a copy. Mone was admitted on the 5th July 2012 having been brought into Northwick Park Hospital by ambulance with an episode of illness. The doctors who treated Mone had not seen this document despite there being a copy in the medical notes.

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	On the 7th July 2012 Mone's condition was stable at the time of the ward round in the morning but had deteriorated by 10.50. Doctors attended and began to treat Mone. Shortly before 11.25 Mone became unresponsive and despite attempts it was not possible to save his life. If Mone had been referred and been accepted by the Royal Brompton Hospital on the 5th or the 6th July 2012 it is likely that he would not have died when he did.
5	**CORONER'S CONCERNS** 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. The **MATTERS OF CONCERN** are as follows. – (1) The development of a flag system for patients, under the care of specialist hospitals, with special clinical requirements to ensure that advice about clinical care is brought to the attention of all treating clinicians.
6	**ACTION SHOULD BE TAKEN** 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** You are under a duty to respond to this report within 56 days of the date of this report, namely by Friday 14th March 2014. 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 Representative of members of the family. 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.
9	**21st January 2014**