REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	THIS REPORT IS BEING SENT TO: **The Chief Executive** **Bedfordshire Clinical Commissioning Group** **Capability House** **Silsoe** **Bedfordshire.** **MK45 4HR**
1	**CORONER** I am **Mr Tom Osborne**, Senior Coroner, for the Coroner Area of Bedfordshire and Luton
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. **http://www.legislation.gov.uk/ukpga/2009/25/schedule/5**
3	**INVESTIGATION and INQUEST** On the 2nd January 2014 I commenced an Investigation into the death of **Gianni KHAN** aged 10. The Investigation concluded at the end of the Inquest on 28th of April 2014. The Conclusion of the Inquest was a narrative conclusion - the medical cause of death being: I(a) Catastrophic Neurological Injury following Traumatic Extradural Haematoma
4	**CIRCUMSTANCES OF THE DEATH** **Gianni Khan** suffered a catastrophic head injury whilst attending a birthday party on 21st December 2013. His mother took him to the Luton & Dunstable Hospital where he was streamed to the urgent GP Clinic. On the 22nd December 2013 he was seen at home by a paramedic and was not taken to hospital. He collapsed on 23rd December 2013 whilst waiting to be seen in his GP Surgery. He was taken to the Luton & Dunstable Hospital and transferred to Addenbrooke's Hospital where he underwent neurosurgery. He died at Addenbrooke's Hospital on 28th December

	2013. Prior to his death there was a failure to recognise the serious nature of his head injury that resulted in lost opportunities to render further medical attention.
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: That when Gianni was taken to the A&E Department at the Hospital and reported that he had suffered a head injury he was "streamed" to be seen in the GP Clinic rather than see a Doctor in the Emergency Department. The Consultant from the Department told me, during the course of his evidence, that it would be 'good practice' for all suspected head injuries to be referred to the A&E Team. I was also told that the Hospital have always requested a full triage before streaming and the Clinical Commissioning Group refused to allow for such a triage.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, as the Chief Executive of the Bedfordshire Clinical Commissioning Group, 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 the 7th **JULY 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 Person(s): The Family The Luton & Dunstable Hospital 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, redacted or summary form. He may also 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	**Dated this 9th day of May 2014** **.....** **Tom OSBORNE** **Senior Coroner** **Bedfordshire & Luton**