Crispin Giles Butler
Assistant Coroner for Buckinghamshire

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Department of Health**
1	**CORONER** I am Crispin Giles Butler, Assistant Coroner for Buckinghamshire
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/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 25/04/2014 I commenced an Investigation into the death of Robert Gordon John Hogg, a boy aged 2 years. The Investigation concluded at the end of the Inquest on 25th June 2015. The conclusion of the inquest was narrative (see attached). The medical cause of death was recorded as:- 1a) Acute Bacterial Bronchopneumonia Streptococcus Pneumoniae Infection Viral Upper Respiratory Tract Infection (Rhinovirus, Human Bocavirus were detected)
4	**CIRCUMSTANCES OF THE DEATH** Robert Hogg was taken to the Bucks Urgent Care Centre, Stoke Mandeville Hospital on 16.04.14 by his parents with a cold and temperature, he was seen by medical staff and assessed under the NICE guideline to be in the Amber category. He was administered antipyretics and was subsequently allowed home when his condition had been assessed in the Green category. Robert's parents were advised to administer Nurofen, monitor him and bring him back if his condition worsened. Robert was off of his food over 19.04.14 - 20.04.14 eating very little, he was complaining of a stomach ache and grunting when he exhaled. Robert's parents gave him a laxative. He had a bowel movement and appeared to improve. On 21.04.14 Robert was lethargic, pale and clingy, his mother called 111 and an appointment was made for 13.24 at Bucks Urgent Care Centre, Stoke Mandeville Hospital. While Robert and his family were in the waiting room, he became limp, pale and unresponsive. He was rushed into the Accident and Emergency Department at 13.43 where CPR was commenced. Robert's death was confirmed by [redacted] on 21.04.14 at 14.27.
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) An Investigation Report (2014/13029) prepared by [redacted] for South Central Ambulance Service (incident no: IR 4865) revealed three areas of concern. (2) The third area of concern stated specifically "NHS Pathways toddler/child Pathways are not necessarily highlighting/picking up very sick children. This is not the first event relating to incidents involving toddlers/children and this has been highlighted through our own Pathways Lead to NHS Pathways for investigation" (3) The evidence given by [redacted] during the Inquest was that no changes have been made to the toddler/child pathways, and that the third area of concern identified in the

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	Investigation Report is a continuing risk.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you Department of Health 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 ~~2nd~~ 6th October 2015. 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:- Family of Robert Hogg South Central Ambulance Service Buckinghamshire Healthcare NHS Trust Care UK [redacted] and to the Local Safeguarding Board (where the deceased was under 18). 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	Dated 6th August 2015 Signature [redacted] Assistant Coroner for Buckinghamshire