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

Telephone 0208 447 7680 Fax 0208 447 7689

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

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 19th day of November 2014 I opened an investigation touching the death of Parv Patel , 4 years old. The inquest concluded on the 14th September 2015 The conclusion of the inquest was "Narrative", the medical case of death was 1a Influenza A infection

4 CIRCUMSTANCES OF THE DEATH

Parv Patel, aged 4 years old, was taken to hospital on the 28th November 2014 suffering with an infection. By 02.00hrs the following morning he had become seriously unwell with symptoms of heart failure as a part of a septic picture, the fact that he was experiencing symptoms of heart failure at this time was not recognized until much later the following day at 09.45 hrs. A doctor decided reasonably, to intubate Parv which, due to the development of a cardiac tamponade, precipitated his cardiac arrest and death at 13.25hrs in the early afternoon.

Parv Patel died following intubation having suffered a rare complication of flu.

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 PEWS scores do not reflect current research into child illness.



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29th September 2015

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And that the Pews scores may tend to act to distract the doctors away from the fact that despite a low PEWS score a child might be seriously ill 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. YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by Wednesday 25th November 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. **COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:-Representatives of the family and the Hospital Trust 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.