## Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

| | |
|---|---|
| | **REGULATION 28 REPORT TO PREVENT DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>[redacted]**, CEO Milton Keynes University Hospital** |
| **1** | **CORONER**<br><br>I am Tom OSBORNE, Senior Coroner for the coroner area of Milton Keynes |
| **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** | **INVESTIGATION and INQUEST**<br><br>On 16 December 2021 I commenced an investigation into the death of Sangeerth GIRIRATHAN aged 23. The investigation concluded at the end of the inquest on 06 May 2022. The conclusion of the inquest was a narrative one as follows:<br><br>*The deceased was involved in a road traffic collision on the 23rd of October 2021 on the M1 motorway in Milton Keynes between Junction 13 and 14 and suffered a traumatic brain injury. Whilst in Milton Keynes University Hospital on the intensive care unit he suffered an anoxic cardiorespiratory arrest due to a blockage of his tracheostomy tube that went unrecognised because the alarm on the monitor was switched off. The delay in recognising the blockage resulted in a lost opportunity to intervene earlier that would have prevented his death. He died on the 12th of December 2021.* |
| **4** | **CIRCUMSTANCES OF THE DEATH**<br><br>See above narrative. |
| **5** | **CORONER'S CONCERNS**<br><br>During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.<br><br>The **MATTERS OF CONCERN** are as follows:<br>(brief summary of matters of concern)<br><br>During the inquest it became apparent that in the ICU the alarms that are operating on the monitors had been disengaged. This resulted in the staff not being alerted when the patient's saturations fell below an acceptable level and he went into cardiac arrest. My understanding is that if a patient is being monitored at all then it is essential that the alarms remain operational. I believe that all staff should be reminded of the need for the alarms to be active so that future deaths in similar circumstances do not arise. |
| **6** | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by July 12, 2022. 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. |
| **8** | **COPIES and PUBLICATION**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons<br>- The family of Mr Girirathan<br><br>I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it.<br><br>I may also send a copy of your response to any person who I believe may find it useful or of interest.<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.<br><br>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: 19/05/2022**<br><br>  <br>**Tom OSBORNE**<br>**Senior Coroner for**<br>**Milton Keynes** |

## Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

**REGULATION 28 REPORT TO PREVENT DEATHS**

**THIS REPORT IS BEING SENT TO:**
**Rt Hon Grant Shapps MP – Secretary of State for Transport**

**1 CORONER**

I am Tom OSBORNE, Senior Coroner for the area of Milton Keynes

**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 16 December 2021 I commenced an investigation into the death of Sangeerth GIRIRATHAN aged 23. The investigation concluded at the end of the inquest on 06 May 2022.

The conclusion of the inquest was a narrative one as follows:

*The deceased was involved in a road traffic collision on the 23rd of October 2021 on the M1 motorway in Milton Keynes between Junction 13 and 14 and suffered a traumatic brain injury. Whilst in Milton Keynes University Hospital on the intensive care unit he suffered an anoxic cardiorespiratory arrest due to a blockage of his tracheostomy tube that went unrecognised because the alarm on the monitor was switched off. The delay in recognising the blockage resulted in a lost opportunity to intervene earlier that would have prevented his death. He died on the 12th of December 2021.*

**4 CIRCUMSTANCES OF THE DEATH**

See above narrative.

**5 CORONER'S CONCERNS**

The MATTERS OF CONCERNS are as follows:

During the course of the inquest it became apparent that the deceased, who was employed as a delivery van driver, had been working for long hours prior to the original collision. It is likely that he may have fallen asleep and collided with the back of a stationary lorry on the M1 motorway. I am told that there are currently no regulations regarding the hours that can be worked by a van driver as opposed to the regulations that operate for heavy goods vehicles. I believe that this is a matter that should be reviewed by the department in order to prevent similar deaths in similar circumstances.

**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 12 July 2022. 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:
The family of Mr Girirathan

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**

**Tom OSBORNE**
**Senior Coroner for**
**Milton Keynes**
**Dated: 19 May 2022**