Inner North London Coroners Court

Regulation 28 Report to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: [redacted] **Medical Director, NHS England**
	CORONER I am Selena Lynch, Assistant Coroner for Inner North 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 6th November 2013 I concluded an inquest into the death of Barnabas Newlyn, a four year old boy. My conclusion was that he died from acute intracerebral haemorrhage due to metastatic Ewing's sarcoma and that his death was natural.
4	**CIRCUMSTANCES OF THE DEATH** Barnabas had received treatment for Ewing's sarcoma and appeared to be in remission. He collapsed at home on 30th March 2013 and was admitted to Queen Elizabeth the Queen Mother Hospital (QEQM) in Margate at about 12.30pm. A scan revealed that he had suffered a large right parieto-occipital haemorrhage. He was transferred to Great Ormond Street Hospital, arriving at about 7 p.m.. He underwent emergency craniotomy, but his condition deteriorated and he died on 31st March 2013.
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. – In the case of Barnabas Newlyn there were particular difficulties in arranging timely transfer, and earlier transfer would have been unlikely to affect the outcome. However, the Court heard that even without such difficulties the time taken to travel by road from QEQM to Great Ormond Street Hospital does not afford a realistic opportunity to save the life of a patient needing time sensitive critical care transfer, especially neurosurgical emergencies. This may be an issue for other similarly placed hospitals elsewhere in the country where they need to transfer patients to specialist facilities at some distance. Whilst recognising that helicopter services are not directly managed or funded by NHS England, it may be helpful and appropriate for healthcare staff needing urgent transfer to start by attempting to secure air transfer.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 **14 January 2014**. I 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: • [redacted] • South East Coast Ambulance Service NHS Foundation Trust • East Kent Hospitals University NHS Foundation Trust • Kent Surrey and Sussex Air Ambulance Trust , • Great Ormond Street Hospital and to the Local Safeguarding Board. I have also sent it to Kent, Surrey and Sussex Air Ambulance Trust who may find it useful or of interest. 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	**19th November 2013** **Signed**