


	<p style="text-align: center;">REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <ol style="list-style-type: none"> 1. Chief Executive Greenbrook Healthcare Hyde Park Hayes 11 Millington Road 4th Floor, Building 3, Hayes, UB3 4AZ 2. Chief Executive Bromley CCG 379 Croydon Rd Beckenham BR3 3QL
1	<p>CORONER</p> <p>I am Jonathan Landau, Assistant Coroner, South London jurisdiction</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INQUEST</p> <p>On 29 April 2019 the court opened an investigation into the death of Francesca Margaux Sio. She died on 1 April 2017.</p> <p>The inquest was concluded on 8 November. I returned a conclusion of natural causes. The medical cause of death was:</p> <p>1a Massive Pulmonary Tumour Embolism 1b Sacro-coccygeal Yolk Sac Tumour</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p>

	<p>Francesca died from a massive embolism caused by a previously undiagnosed tumour.</p>
5	<p>CORONER'S CONCERNS</p> <p>During the course of the inquest, the evidence revealed a matter giving rise to concern that in my opinion means that there is still a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.</p> <p>The MATTER OF CONCERN is as follows. -</p> <p>Three days before she died, Francesca attended the urgent care centre in the grounds of Princess Royal University Hospital run by Greenbrook Healthcare. She waited nearly 4 hours to be assessed by a doctor and was then referred appropriately to the paediatric accident emergency department in the hospital.</p> <p>I heard unchallenged expert evidence during the hearing that mixing adult and child patients in urgent care centres risked children quietly deteriorating unnoticed.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 10th January 2020. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the following Interested Persons:</p> <p>Francesca's family Greenbrook Healthcare</p>

	<p>King's College Hospital NHS Trust</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>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.</p>
9	<p>15 November 2019</p> <p></p> <p>Jonathan Landau, Assistant Coroner for South London</p>