## 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>**1 [redacted], Executive Officer - Association of Ambulance Chief Executives**<br>**2 [redacted], Chief Executive Officer - Royal College of Emergency Medicine**<br>**3 [redacted], Chief Executive Officer - Royal College of General Practitioners**<br>**4 [redacted], Chief Executive Officer – Urgent Health UK** |
| **1** | **CORONER**<br><br>I am Sean CUMMINGS, Assistant 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 12 May 2022 I commenced an investigation into the death of Leonard Jomo Isaac KING aged 37. The investigation concluded at the end of the inquest on 25 April 2023. The narrative conclusion of the inquest was that:<br><br>Mr Leonard Jomo Isaac King died at Milton Keynes University Hospital on the 4th May 2022 after collapsing with a hypoxic cardiac arrest consequent on blockage of his airway because of epiglottitis. There was a missed opportunity to recognise and escalate his case at the Milton Keynes Urgent Care Centre on the 2nd May 2022. There was a further missed opportunity by South Central Ambulance Service when they were called via 999 to his home on the 2nd May 2022 later that day afternoon, to recognise the fact that he was in a precarious position and removing him to the ED. This was an avoidable death. |
| **4** | **CIRCUMSTANCES OF THE DEATH**<br><br>Mr Leonard Jomo Isaac King died at the Milton Keynes University Hospital on the 4th May 2022 as a result of a hypoxic cardiac arrest secondary to an obstructing epiglotittis. |
| **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>Acute epiglottitis, also known as supraglottitis, is an infection of the tissues of the epiglottis and surrounding tissue that has potential to cause a sudden, complete and fatal obstruction to the airway.<br><br>Prior to mass immunisation of children against Haemophilus Influenzae the disease was predominantly confined to young children. |

| | |
|---|---|
| | Subsequent to mass immunisation the demographic has changed and more adults are developing epiglottitis. It is not common in this group but because of the expectation among clinicians that it is a still a disease of children, there is a tendency, except in those routinely dealing with acute emergencies of the airways, to regard typical symptoms as those of a sore throat or tonsillitis and not as the harbinger of sudden catastrophic obstructive epiglottitis.<br><br>The disease classically develops rapidly in children but in adults may take several days which may be falsely reassuring. Typical symptoms may include a sore throat which becomes more severe with time, difficulty swallowing secretions, pain on swallowing and an alteration in voice. Prompt recognition and treatment is lifesaving.<br><br>Education and training in the movement of epiglottitis into the adult population may assist in recognition and early treatment. |
| **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 October 10, 2023. 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>- Family of Mr King<br>- Milton Keynes Urgent Care Centre<br>- South Central Ambulance Service<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: 15/08/2023**<br><br>**Sean CUMMINGS**<br>**Assistant Coroner for**<br>**Milton Keynes** |