Regulation 28: Prevention of Future Deaths report

Riya HIRANI (died 28.12.22)

	THIS REPORT IS BEING SENT TO: **1. The Rt Hon Steve Barclay MP** **Secretary of State for Health and Social Care** **House of Commons** **London SW1A 0AA** **2. [redacted]** **National Medical Director** **NHS England** **Wellington House** **133-135 Waterloo Road** **London SE1 8UG**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 30 December 2022, one of my assistant coroners, Jonathan Stevens, commenced an investigation into the death of Riya Hirani, aged 9 years. The investigation concluded at the end of the inquest yesterday. I made a narrative determination, a copy of which I attach. Riya's medical cause of death was: 1a hypoxic ischaemic encephalopathy 1b out of hospital cardiac arrest 1c invasive group A streptococcal infection and influenza B infection

4	**CIRCUMSTANCES OF THE DEATH** Riya died in Great Ormond Street Hospital, having been transferred there from Northwick Park Hospital in Harrow after she presented in cardiac arrest on the evening of 23 December 2023. However, by that point Riya's condition was irretrievable, and she died five days later.
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. Riya's mother took her to hospital a full day before Riya's fatal collapse, because she believed that Riya was very sick. Unfortunately, the junior doctor who examined and assessed Riya failed to appreciate the severity of her condition. Instead of giving her intravenous antibiotics and admitting her to hospital, he diagnosed a virus and discharged her with advice to take over the counter painkillers and a sheet describing the management of sore throats. I intend to make a PFD report to the medical director of Northwick Park Hospital about the diagnosis and treatment of Riya's condition. However, I am writing to you both because it seems to me that there is a fundamental issue regarding the lack of appropriate diagnosis and treatment that is apparent locally but relevant nationally. When Riya's mother took her to hospital, she did so because it seemed to her that this illness was qualitatively very different from any other that Riya had suffered in her nine years. In short, Riya's mum was convinced that Riya was extremely ill, she articulated clearly and at every stage in hospital why she thought that Riya was extremely ill, and she even questioned the doctor about whether this could be a group A streptococcal infection. (There was a well publicised outbreak at the time and the hospital had actually received an alert about this.) I heard at inquest that, even in the middle of the night, there was a consultant available to give a second opinion if this had been requested by medical personnel. However, no thought was given to seeking a second opinion. I think it highly likely that if it had been open to Riya's family to seek a second opinion at that point, they would have done so without hesitation. One of the reasons that coroners are local to an area is because this makes them better placed to recognise any local trends.

	Although the events bringing the two children to hospital were very different, as I listened to the evidence at Riya's inquest I noticed some striking similarities between the circumstances of Riya's treatment and those of Martha Mills. On each occasion a parent's articulately expressed and ultimately prescient concerns about a previously healthy but rapidly deteriorating child, did not result in appropriate escalation of care. I heard the inquest touching Martha's death last year. I am aware from press reports of the attempts of Martha's mother to enable families in such a situation to have ready access to a second medical opinion. It seems to me that you should be aware of the circumstances of Riya's death before you decide how to proceed.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 13 November 2023. 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 following. • [redacted], the parents of Riya Hirani • [redacted], the parents of Martha Mills • [redacted], medical director, Northwick Park Hospital • HHJ Thomas Teague QC, the Chief Coroner of England & Wales 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. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**DATE** **SIGNED BY SENIOR CORONER** 15.09.23 *ME Hassell*