Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 NHS England and NHS Improvement**
1	**CORONER** I am Tom OSBORNE, Senior Coroner for the coroner 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 02 November 2022 I commenced an investigation into the death of Rohan GODHANIA aged 16. The investigation concluded at the end of the inquest on 21 July 2023. The narrative conclusion of the inquest was: The deceased was admitted to West Middlesex Hospital on 16th August 2020. His hyperammonaemia and OTC deficiency was not diagnosed. The failure to carry out a test for ammonia that would have revealed the hyperammonaemia resulted in a lost opportunity to render further medical treatment that may, on the balance of probabilities, have prevented his death. He died on 18th August 2020.
4	**CIRCUMSTANCES OF THE DEATH** The deceased consumed a high protein drink on 15th August 2020 and became unwell. He was admitted to West Middlesex Hospital. Advice was taken from the neurologists at Charing Cross Hospital who advised that he should be tested for ammonia. The test was not carried carried out. His condition deteriorated and he died from Ornithine Transcarbamylase Deficiency (OTC) on the 18th August 2020.
5	**CORONER'S CONCERNS** 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. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) During the cause of the evidence I had two concerns regarding the treatment of the deceased that, as part of my duty as a coroner, I am bringing to your attention 1. Age classification of Teenagers 16-18 within the NHS There seems to be a lack of clarity and consistent guidance across the NHS regarding the appropriate classification of teenagers aged 16-18. The question of whether they should be treated as paediatric patients or adults is leading to confusion and potential disparities in the care provided. I consider that this should be urgently reviewed by NHS England and if necessary the guidance on age classification updated ensuring that all healthcare providers

	adhere to a unified approach emphasising the importance of consistent and appropriate care for this age group. 2. Guidance for Testing for Ammonia in Emergency Departments The other concerning issue that requires immediate attention is the lack of guidance for testing ammonia levels in patients who present in extremis with an unknown cause . Timely and accurate diagnosis is essential in such cases to ensure appropriate treatment and prevent unnecessary deaths. The guideline should include clear protocols for conducting ammonia tests, interpreting the results and making informed clinical decisions based on the findings. The guidance should be disseminated to all emergency departments and healthcare facilities.
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 October 02, 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 Chief Coroner and to the following Interested Persons **The family of Rohan Godhania** **West Middlesex Hospital NHS FT** **Imperial College NHS FT** I have also sent it to the Care Quality Commission who may find it useful or of interest. 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 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 by the Chief Coroner.
9	**Dated: 09/08/2023**  **Tom OSBORNE** **Senior Coroner for**

	Milton Keynes