

# M. E. Voisin Her Majesty's Senior Coroner Area of Avon

26th April 2018 REF:

**REGULATION 28 REPORT TO PREVENT FUTURE DEATHS** THIS REPORT IS BEING SENT TO: **University Hospitals Bristol NHS Trust Trust Headquarters** Marlborough Street Bristol BS1 3NG CORONER 1 I am M E Voisin Senior Coroner for Area of Avon 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 18/10/2017 I commenced an investigation into the death of Yazin ELHJAJE. The investigation concluded at the end of the inquest 26th April 2018. The conclusion of the inquest was a narrative which read as follows: Yazin died from bacterial meningitis which was diagnosed on 7th October 2017. He had been unwell for about a week with a headache but since 5<sup>th</sup> October developed a fever. On 7<sup>th</sup> October at 2am he was seen at the hospital examined and discharged, he did not have a full set of observations and his discharge letter stated that meningitis had not been completely ruled out. He was discharged at 2.45 am and his condition over the day deteriorated. He was taken by ambulance to the hospital at around 5pm on 7<sup>th</sup> October 2017 but died on 8<sup>th</sup> despite the treatment provided at that time. 4 CIRCUMSTANCES OF THE DEATH Yazin Elhjaje became ill on 6th October 2017 and was taken to see his general practitioner, she was concerned about his presentation and that it could be meningitis, he was managed at home and then taken to hospital later that day with a letter from the general practitioner raising her concern. Yazin was

2017 at Bristol Royal Hospital for Children Upper Maudlin Street Bristol

examined and discharged with a diagnosis of sinusitis. His condition deteriorated over the next few hours and he was taken back to the hospital by ambulance, by now he was very ill, it was confirmed that he probably had meningitis, his condition deteriorated despite the treatment and he died on 8th October

## 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. -

I heard during the inquest that the safety-netting advice on discharge given to Yazin's parents was in relation to his headaches and not in relation to the differential diagnosis of meningitis.

I would ask that consideration is given to the safety-netting advice provided to parents in cases where meningitis has been considered as part of the differential diagnosis as in this case.

## 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 26<sup>th</sup> June 2018 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 - and to the LOCAL SAFEGUARDING BOARD (where the deceased was under 18)].

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 26/04/2018

Signature\_

M E Voisin Senior Coroner Area of Avon