Regulation 28: Prevention of Future Deaths report

William David Patrick HEWES (died 21.01.23)

	THIS REPORT IS BEING SENT TO: **1. Medical Director** **Homerton University Hospital NHS Trust** **Homerton Row** **London E9 6SR**
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 25 January 2023, I commenced an investigation into the death of William Hewes aged 22 years. The investigation concluded at the end of the inquest earlier today. I made a narrative determination, which I attach.
4	**CIRCUMSTANCES OF THE DEATH** William was a fit and healthy young man who died from meningococcal septicaemia.
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. William's life threatening condition was recognised immediately he attended hospital, but he did not receive the necessary treatment as promptly as he should have done. The cause of the delay was multi factorial. I heard at inquest that the Homerton University Hospital NHS Trust has done a great deal of work since William's death to try to avoid this sort of situation arising in the future. If future patients at the Homerton can benefit from William's death, then why not future patients elsewhere? It seems to me that there would be great merit in sharing the learning nationally.
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 26 May 2025. 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. • The mother of William Hewes • The father of William Hewes • The Care Quality Commission for England • HHJ Alexia Durran, 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. She may send a copy of this report to any person who she 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** 27.03.25 *ME Hassell*