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 Secretary of State for Health and Social Care** **2 Northampton General Hospital** **3 NHS ENGLAND**
1	**CORONER** I am Hassan SHAH, Assistant Coroner for the coroner area of Northamptonshire
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 20 December 2022 I commenced an investigation into the death of Akhona MOYO aged 4. The investigation concluded at the end of the inquest on 27 January 2026. The conclusion of the inquest was that: Akhona Moyo died 26 November 2022 at Queens Medical Centre, Nottingham as a result of a brain tumour. Had he been admitted to hospital on 23rd November 2022, scanned earlier in the day on 24 November 2022 and received earlier intervention directed at reducing intracranial pressure, he probably would have survived.
4	**CIRCUMSTANCES OF THE DEATH** Akhona Moyo died 26 November 2022 at Queens Medical Centre, Nottingham as a result of a brain tumour. Had he been admitted to hospital on 23rd November 2022, scanned earlier in the day on 24 November 2022 and received earlier intervention directed at reducing intracranial pressure, he probably would have survived. The medical cause of death was: - 1a. Acute obstructive hydrocephalus 1b. Posterior fossa ependymoma A narrative conclusion was given as above.
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) Hospital doctors, including in the Emergency Department and Paediatrics, do not have electronic access to primary care medical notes e.g. GP notes, community mental health notes etc. At Northampton General Hospital, a new electronic system known as "Nerve

	Centre" contains only hospital notes. Hospital doctors also have access to the "Northamptonshire Care Record" which contains basic lists of GP visits and medication, but no detailed entries. All the doctors that gave evidence to the Inquest stated that access to primary care records would undoubtedly assist them in delivering better patient treatment and care. It was felt that access to such information was particularly important in cases such as the present when a patient is autistic and non-verbal. There may be a multitude of other reasons why a patient or their family may not be able to relay to doctors a full and accurate medical history. Access may also enable doctors to have a more global view of a patient's medical condition rather than, as it was put at Inquest, "working in silos".
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 March 24, 2026. 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 [redacted] **Northampton General Hospital** **Delapre Medical Centre** 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: 28/01/2026** [redacted] **Hassan SHAH** **Assistant Coroner for** **Northamptonshire**