

Summary of Regulation 28 Report to Prevent Future death: Rohan Godhania (died 18/8/2020)

This is a brief summary of the regulation 28 coroners report into the death of *Rohan Godhania* from which you can review the coroner recommendations to health care and consider whether there are changes you could implement in your local NHS trust to address them

Clinical summary

16 year old boy who was previously well

Events around death

- Rohan consumed a high protein drink & became unwell
- Admitted to hospital with neurology input
- Recommended ammonia test was not carried out
- Patient deteriorated and died from hyperammonaemia and undiagnosed Ornithine Transcarbamylase Deficiency (OTC)

Coroner's Recommendations

- Urgent review of classification of those aged 16-18 as adult or paediatric patients
- Guidance for ammonia testing in patients presenting in extremis with an unknown cause
- Consider adding warning labels to high protein drinks about potential risks in undiagnosed urea cycle disorders

Key Themes

- Inconsistency & uncertainty in who is the most appropriate team to care for 16-18 year olds leading to issues with care quality
- Lack of guidance for testing ammonia levels in urgent care settings
- High protein supplements are easily accessible to the public without adequate information about potential dangers

Local Improvement suggestions from this report

- To formulate and unify an approach as to whether teenagers aged 16-18 should be treated as paediatric or adult patients. Is the care consistent and appropriate?
- Disseminate up-to-date guidance on timely and accurate use of ammonia testing in Emergency Departments
- Consider campaign to ensure high protein products contain relevant warnings, signs and symptoms for those unaware they are at risk of life-threatening medical complications if ingested

For full information visit:
<https://www.judiciary.uk/prevention-of-future-death-reports/rohan-godhania-prevention-of-future-deaths-report> or follow the QR code:

