REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1. **Dr Andrew Morris, Chief Executive, Frimley Park Hospital, Camberley, Surrey**
2. **Dr Hilary Cass, President, Royal College of Paediatrics and Child Health**
3. **Rt Hon Jeremy Hunt MP, Secretary of State for Health**

CORONER

I am Karen HENDERSON, assistant coroner for the coroner area of Surrey

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

INVESTIGATION and INQUEST

On 20th March 2014 I commenced an investigation into the death of Jackson J Chadd, 5 months of age. The investigation concluded at the end of the inquest on 20th March 2014. The medical cause of death given was:
1a. Septic shock due to fulminant Meningococcal infection
1b.
1c
2.
My narrative conclusion was: **Jackson J Chadd died from fulminant meningococcal septicaemia where the evolving nature of his illness was not recognised or treated**

CIRCUMSTANCES OF THE DEATH

Jackson was a fit and healthy baby until he became unwell at home on the 6th August 2012. He was irritable, not feeding well, crying with a temperature, tachycardia (160 bpm) and a raised respiratory rate (>60). [redacted] took the advice of her GP to go to A&E with a possible diagnosis of her son having sepsis. Jackson was triaged in A&E at 5pm, found to have a high temperature and a raised heart rate and respiratory rate. He was given paracetamol for his temperature. He was reviewed by the A&E team who referred him to the paediatricians with a possible diagnosis of sepsis. He was then seen at approximately 7pm by a non-career ST2 (GP trainee) paediatrician who had been in post for one week with no previous paediatric experience. Some tests were initiated for sepsis. A discussion was had between the ST2 and the paediatric SpR who, for unknown reasons, did not review Jackson. Throughout his time in A&E, Jackson continued to have a high temperature (>38.5) that did not settle with paracetamol or ibuprofen. His other observations were variable but remained abnormal or at the upper limits of normal. No blood pressures were carried out after an attempt at triage failed. During his time in A&E Jackson had a number of bouts of severe foul smelling diarrhoea and developed a generalised maculo-papular rash with at least 2-3 noticeable non-blanching spots. He was seen by the on call SpR for the first and only time at 23.30, 7hrs after arriving in A&E. Jackson was discharged with a diagnosis of gastroenteritis. No significance was placed on the rash or the non-blanching spots. There is a conflict between his mother's belief of how unwell her son was (floppy, pale and lethargic with no obvious signs of improvement) and that of the SpR (smiling, not floppy etc) and she was unhappy Jackson was not admitted. Jackson was taken home but his condition deteriorated and his parents brought him back at or around 0200 where he was found to be in septic shock. Despite aggressive resuscitation Jackson was certified dead at 06.05 on 7th August 2014. He had two sets of vaccination with the third (delayed by a month by a cold) arranged for the day after his death.

CORONER'S CONCERNS

During the course of the inquest the evidence revealed matters giving rise for concern. In my opinion there is a risk that future death 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:

1. Lack of effective supervision of a non-career grade paediatrician with no previous experience
2. Lack of consultant supervision of 'out of hours' on-call paediatric trainees
3. Lack of independent consultant assessment of paediatric admissions into Frimley Park Hospital outside normal working hours
4. Lack of effective application of national guidelines for assessment and investigation of fever in children less than one year of age
5. Failure to acknowledge or act on the concerns of a parent

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and your organisation: Frimley Park Hospital NHS Trust, Royal College of Paediatrics, and the Secretary of State for Health have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 27th May 2014. I, the coroner, may extend this 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [redacted] (parents), [redacted] who may find it useful or of interest.

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.

DATE: **SIGNED:**