Nicola Jane Mundy
Senior Coroner for South Yorkshire (East District)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Medical Director Chief Executive** Doncaster and Bassetlaw NHS Foundation Trust Doncaster Royal Infirmary, Armthorpe Road, Doncaster DN2 5LT
1	**CORONER** I am Nicola Jane Mundy, Senior Coroner for South Yorkshire (East District)
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 25/07/2013 I commenced an investigation into the death of Zakariyya Thomas Clark. The investigation concluded at the end of the inquest on 6 October 2014. The conclusion of the inquest was Natural causes.
4	**CIRCUMSTANCES OF THE DEATH** On the 11th July 2013 Zakariyya Clark's mother was getting up from a mattress on the floor when she slipped and dropped him. He landed on his head and sustained bi-lateral skull fractures and two minor bleeds in the brain. The neuropathologist said none of these injuries were life threatening. Zakariyya was taken to the Doncaster Royal Infirmary where he was examined and discharged with no CT scan being undertaken as he did not satisfy the NICE Guidance for doing so and there were no clinical indications, according to the assessing doctor. There was no evidence that any observations were undertaken with regard to heart rate, temperature etc. Thereafter, apart from being a little bit grizzly due to teething, Zakariyya seemed to be well and his usual self and his family had no concerns whatsoever. On the evening of the 15th/16th of July 2013 Zakariyya was given his night time feed which he took in full before he was settled and he went to sleep. The following morning when his parents awoke (all three shared the same bed) Zakariyya was unresponsive and the emergency services rapidly attended but declared life extinct. A number of pathological experts were involved in the autopsy examination and ancillary investigations, two of whom attended court to give evidence namely the Home Office Pathologist and the Neuropathologist. The cause of death offered was Unascertained with a number of possibilities being postulated. These included death from infection, overlay, traumatic head injury or Sudden Infant Death Sydrome. After hearing the evidence, the conclusion was that this was Sudden Infant Death Syndrome and Natural Causes recorded as the conclusion.
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.

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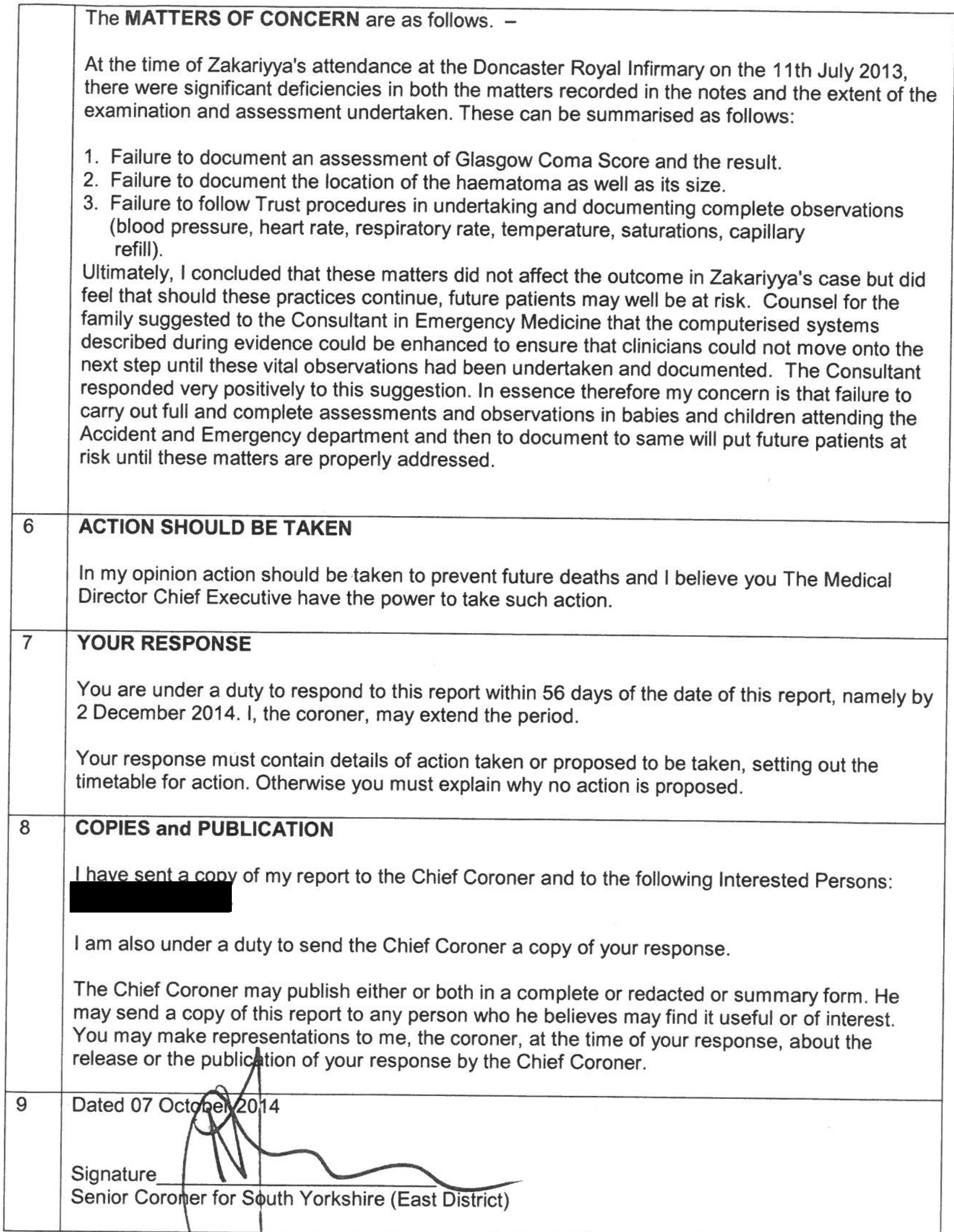

	The **MATTERS OF CONCERN** are as follows. – At the time of Zakariyya's attendance at the Doncaster Royal Infirmary on the 11th July 2013, there were significant deficiencies in both the matters recorded in the notes and the extent of the examination and assessment undertaken. These can be summarised as follows: 1. Failure to document an assessment of Glasgow Coma Score and the result. 2. Failure to document the location of the haematoma as well as its size. 3. Failure to follow Trust procedures in undertaking and documenting complete observations (blood pressure, heart rate, respiratory rate, temperature, saturations, capillary refill). Ultimately, I concluded that these matters did not affect the outcome in Zakariyya's case but did feel that should these practices continue, future patients may well be at risk. Counsel for the family suggested to the Consultant in Emergency Medicine that the computerised systems described during evidence could be enhanced to ensure that clinicians could not move onto the next step until these vital observations had been undertaken and documented. The Consultant responded very positively to this suggestion. In essence therefore my concern is that failure to carry out full and complete assessments and observations in babies and children attending the Accident and Emergency department and then to document to same will put future patients at risk until these matters are properly addressed.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you The Medical Director Chief Executive 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 2 December 2014. 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: 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	Dated 07 October 2014 Signature____________________ Senior Coroner for South Yorkshire (East District)

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