

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>(1) Mr Richard Jefferson Head of Business Systems NHS England</p>
1	<p>CORONER</p> <p>I am R Brittain, Assistant Coroner for Warwickshire</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>The investigation into the death of Evelyn Mary Smith concluded at the end of the inquest on 5 September 2014. The cause of her death was Acute Ulcerative Laryngotracheobronchitis; the conclusion of the inquest was narrative (copy attached).</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Miss Smith was 7 years old at the time of her death on 13 September 2013. She did not have a significant past medical history. The illness which resulted in her death began on 11 September 2013. She awoke in the early hours of 12 September with difficulty in breathing. This prompted her mother to take her to the Accident and Emergency (A&E) Department at Warwick Hospital (part of South Warwickshire NHS Foundation Trust). She was seen by a Foundation Year 2 (FY2) doctor who had 8 weeks undergraduate and no postgraduate experience in paediatrics. This doctor diagnosed Miss Smith as having 'viral croup' and prescribed steroid medicine (Dexamethasone). Miss Smith was discharged after the FY2 doctor discussed her case with a more senior 'Specialty A&E Registrar'. Both doctors were reassured that her vital signs were improving, although she did have a persisting fever and a heart rate above the normal range.</p> <p>Later on the 12 September 2013 Miss Smith's family arranged for her to be reviewed at her GP practice because of ongoing concerns. She was seen by an Advanced Nurse Practitioner, who diagnosed tonsillitis and prescribed antibiotics. Her respiratory rate, along with other vital signs, were not documented as part of this consultation.</p> <p>On 13 September 2013 Miss Smith remained unwell and was taken back to her GP. She was seen by a doctor who again diagnosed viral croup. Her GP accessed a 'clinical mentor' tool on the practice computer system, which highlighted a scoring algorithm to classify the severity of croup. Miss Smith was scored as having moderate croup which, the scoring classification suggests, warranted admission to hospital. However, after treatment with a Salbutamol nebuliser (instituted because of a recent insect sting), Miss Smith's GP felt that she had improved and prescribed a further course of oral steroid</p>

	<p>medication (Prednisolone). She was not admitted to hospital and returned home.</p> <p>Whilst at home later on 13 September, Miss Smith suffered an acute deterioration in her breathing, at which point she had a cardiac arrest. Despite the institution of early resuscitation and rapid transfer to hospital by paramedics, it was not possible to revive her and she was pronounced dead at Warwick Hospital.</p> <p>A <i>post-mortem</i> examination demonstrated the presence of a virus (Parainfluenza Virus Type 2) and a bacterium (<i>Staphylococcus Aureus</i>) as infectious organisms, which resulted in Acute Ulcerative Laryngotracheobronchitis.</p>
5	<p><u>CORONER'S CONCERNS</u></p> <p>During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths may occur, unless action is considered. In the circumstances it is my statutory duty to report to you.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <p>(1) The care provided to Miss Smith was reviewed by an independent paediatrician and a General Practitioner. I heard evidence that the accurate and consistent recording of Miss Smith's vital signs may have allowed earlier recognition of the severity of her illness. I also heard that the use of the Paediatric Early Warning Scoring system in General Practice may be a useful way of documenting this information. However, it was clear that information in this form is not easy to enter into GP medical records.</p> <p>(2) From the evidence heard at Miss Smith's inquest it was apparent that the scoring system for croup severity was not widely known amongst the clinicians involved in her care. However, her GP did learn of this scoring system after reviewing the 'clinical mentor' tool through the practice's computer software.</p> <p>I heard evidence that systems are in place to prompt entry of certain clinical parameters in specific scenarios; predominantly chronic disease review consultations, such as for diabetes and asthma etc. I am concerned that the GP computer system contains important and clinically relevant information, such as the croup severity score but does not alert the clinician to complete it. I heard that it should be possible to prompt the entry of relevant clinical parameters after a diagnostic code has been entered into a consultation record.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion, consideration should be given as to whether action is required to prevent future deaths. I believe the addressee has the power to make such a consideration and take appropriate action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 7 November. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested</p>

	<p>Persons (a) The Smith family, (b) South Warwickshire NHS Foundation Trust and (c) Miss Smith's General Practitioners</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	12 September 2014 Assistant Coroner R Brittain