REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Practice Manager, Lockfield Surgery, Croft/Gomer Street, Willenhall, West Midlands, WV13 2DR** **2. Chief Executive, New Cross Hospital, Wolverhampton Road, Wolverhampton, West Midlans,WV10 0QP**
1	**CORONER** I am Zafar Siddique, Senior Coroner, for the coroner area of the Black Country.
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 25 September 2015, I commenced an investigation into the death of Baby Ryan Singh Bhogal. The investigation concluded at the end of the inquest on 29 January 2016. The conclusion of the inquest was the deceased died by way of natural causes on the 11 September 2015 from 1a. Hypotensive Shock 1b. Acute Myeloid Leukaemia with t(9;11)(p22;q23)KMT2A-MLLT3
4	**CIRCUMSTANCES OF THE DEATH** 1. During the course of the inquest over two days, I heard evidence that Ryan was born on the 9 January 2014 and was by all accounts a thriving and healthy baby and toddler during the early part of his life. Like any other child he would pick up colds and coughs which were fairly routine and as responsible parents they would seek advice from their GP or Walk in centre staff as necessary. He began crawling at around 8 months and hit all his key developmental targets and was up to date with immunisations. To all intents and purposes he was a thriving healthy baby boy. 2. The frequency of visits to their GP was increasing and from the 17 September 2014 to the 7 September 2015 there were over 20 visits. In addition there were several visits to walk in centres and five visits to New Cross Hospital. On each occasion, he presented with various symptoms including raised temperature, history of falls, and was seen by various Health professionals from Junior to Senior Doctors including Consultant Paediatricians and Advanced Practitioner Nurses. 3. On the vast majority of occasions, he was diagnosed with a vial illness including tonsillitis and the parents were reassured and given painkillers and antibiotics to treat him as necessary. 4. We also heard evidence that on more than one occasion, the parents described symptoms of bleeding gums, puffy eyes, unexplained bruising to his leg and the development of a lump appearing on his head lasting for several weeks.

	5. We heard descriptions of "Red flags" for Leukaemia and with hindsight, the General Practitioner representing the surgery, accepted that there may have been "missed opportunities" and that partly, due to the lack of continuity in respect of which GP saw him may have played a factor in not picking up potential red flags earlier and seeking a second opinion or requesting a blood test. 6. We also heard in evidence that he visited New Cross Hospital a number of times. We heard in evidence from the various clinicians who treated Ryan specifically from the period 25 July 2015 through to 9 September 2015. In particular, on the 25 July, Ryan presented with a history of fever for three days and we are told there was no evidence of any enlargement of the liver or spleen. There were no signs of rash and he was eventually discharged home with paracetamol. 7. He was readmitted on the 27 July and he had developed a cough and blanching rash on his neck, back and chin. He also had a red inflamed throat and elevated pulse. This was diagnosed as oral thrush and a viral infection and he was discharged after one set of observations. Again no blood tests were ordered. When I asked the question, whether the Hospital staff had access to GP records, the answer was yes; however, they would only be accessed if there was a valid reason to do so, for example, a safeguarding concern and the records themselves would sometimes appear upside down. [redacted] medical opinion was that had a blood test been done on the 7 September it is possible that Leukaemia could have been diagnosed. It is not clear if that earlier diagnosis would have made a material difference to the outcome. 8. Ryan then returned on the 7 September and when examined he was found to have a slightly distended abdomen. He also had a raised pulse and his throat was red with exudates on his right tonsil. We heard he was subsequently discharged again when his pulse rate had improved. 9. He was then admitted to the Paediatric Assessment Unit at the same Hospital and a full blood test was requested and it was noted that the liver and spleen were enlarged. Blood tests later showed metabolic acidosis and low blood sugar levels. The results for the blood test were available at around 4.30pm (they were requested at 1pm). At this stage the true extent of Ryan's condition was realized and a proposed diagnosis of Acute myeloid Leukaemia. 10. Both parents were spoken to shortly after 6pm and he was then transferred to Birmingham Children's Hospital. Urgent chemotherapy treatment was started but sadly Ryan deteriorated rapidly and passed away on the 11 September 2016. 11. It was not clear on the balance of probability if an earlier diagnosis or blood test in August or September would have made a difference to the outcome because this type of Leukaemia is a particularly aggressive form of the disease with a survival rate of around 40 per cent.
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. The **MATTERS OF CONCERN** are as follows. –

	1. There was a lack of continuity and overall ownership in terms of treatment Ryan received at the GP practice. He was seen by different Doctor's including Locum staff with no overall holistic approach. This surgery may wish to consider reviewing their policy and management of children who appear excessively for treatment to ensure that there is continuity of care and appropriate measures are in place. In addition you may wish to consider reviewing the systems in place in identifying "Red Flags" and seeking a second opinion or requesting further tests where symptoms or unexplained illnesses are identified for an extended period. 2. The Royal Wolverhampton NHS Trust may wish to consider reviewing their policy in in relation to when it is appropriate to review GP medical records during Hospital admissions. This is particularly important for young children in order to have a clearer history of the patient's presentation before reaching a diagnosis and treatment regime.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 30 March 2016. 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, Ryan's parents, [redacted] 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	**2 February 2016**