REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, Walsall Healthcare NHS Trust, c/o Manor Hospital, Moat Road, Walsall, WS2 9PS** **2. Parents of the late Kinga Cieciorska.**
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 11 March 2016, I commenced an investigation into the death of the child, Kinga Cieciorska. The investigation concluded at the end of the inquest on 10 June 2016. The conclusion of the inquest was the deceased died by way of natural causes contributed to by neglect. The cause of death was: 1a) Peritonitis 1b) Perforated gastric ulcer 2) Cerebral Palsy
4	**CIRCUMSTANCES OF THE DEATH** 1. Kinga was a 16 year old girl born with a number of complex medical needs including cerebral palsy, scoliosis, and dislocated right hip and was visually impaired. She was on various medications including Diclofenac and one of the recognised side effects is stomach ulcers. 2. Her parents became concerned and she appeared to be in pain and discomfort with her abdomen becoming distended. The family took her to her GP and he advised that she should be admitted to Hospital for checks. She was subsequently taken to Walsall Manor Hospital. He also sent notes of his examination and background medical history for the Hospital to use to assist in any diagnosis. It transpired during the inquest that these notes provided by the GP were not seen by the Junior Doctor or Triage Nurse who initially examined her when she arrived. 3. The Junior Doctor after examination recorded that her abdomen was soft and tender. The family asked for an ultrasound scan but this wasn't considered necessary and the working diagnosis was constipation. The Junior Doctor discussed the case with his supervising Consultant, and he advised that an ECG be performed and that further advice should be sought from the on call Paediatrician. The ECG revealed sinus tachycardia. 4. The Junior Doctor didn't record the name of the Paediatrician he spoke to but says he was advised there was no problem or concerns in relation to the tachycardia and she could be discharged with Movicol medication for constipation.

	5. The Paediatrician identified by the rota provided a statement denying he had given any advice in relation to the patient and couldn't recollect any conversation with the Junior Doctor. 6. Kinga was discharged home. Her condition deteriorated rapidly overnight and she became unresponsive. She was urgently taken back to Hospital in her father's car on the morning of the 11 March. Sadly, despite resuscitation attempts she couldn't be revived and had passed away.
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. Evidence emerged during the inquest that the abnormal ECG trace and tachycardia needed further investigation and she should have been subject to further tests and admitted for further observation to establish the cause of the tachycardia. This was effectively a missed opportunity to render basic medical care. On the balance of probability it is more likely than not, she may have survived or life may have been extended if tests had been done to confirm the diagnosis of peritonitis and appropriate treatment commenced. 2. During the inquest it emerged there was evidence of systemic failings in recording of and transmission of information. The Junior Doctor failed to record the name of the Specialist Paediatric Registrar giving advice. More worryingly the Paediatric Registrar at inquest could not recollect giving any advice in relation to the patient. It also emerged during the inquest that medical notes provided by the GP were given to reception staff by the parents on admission. Unfortunately these documents were not forwarded or seen by the Junior Doctor on examination of the patient. 3. It also emerged during the inquest that details of her medication including the significance of the drug, Diclofenac was not considered. One of the contra-indications of this drug for long term users is gastric ulcers. Many people take NSAIDs without having any side effects, but there's always a risk the medication could cause problems, such as stomach ulcers, particularly if taken for a long time or at high doses.
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. 1. Although some improvements have been made by the Trust through the findings of the Root Cause Analysis investigation. You may consider that expediting some of the action points including the creation of a single patient file should happen sooner rather than later. In addition you may wish to consider refresher training for those individuals involved in record keeping and systems for transfer of information. 2. You may also wish to consider expediting the process to establish direct access for children to the Paediatric Department with complex medical needs. A review should also be considered of checking history of patient medication to rule out any contra-indications of drugs during diagnosis.

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 8 August 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; family of the late Kinga Cieciorska. 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	**13 June 2016** **Mr Z Siddique** **Senior Coroner** **Black Country Area**