Esmee Shayla Polmear

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO:
	NHS England Kernow Clinical Commissioning Group
1	CORONER
	I am Dr Elizabeth Emma Carlyon, Senior Coroner for the area of Cornwall and the Isles of Scilly.
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
	Esmee Polmear died on 1 st July 2015 and an investigation commenced on 15 th July and an inquest was opened on 20 th October 2015. A full day hearing was held on 13 th April 2016
4	CIRCUMSTANCES OF THE DEATH
	Esmee Polmear (DoB 13.03.08) felt ill whilst going on a school trip from her Primary School in Perranporth, to Perranporth Beach on the morning of the 1 st July 2015. On her return she collapsed and went into cardiac arrest. Paramedics attended and she was transferred to the Royal Cornwall Hospital where despite attempts at resuscitation she was recognised dead. She died from Pulmonary veno-occlusive disease which is a rare life limiting condition. She had been under the investigation of her GP and the Royal Cornwall Hospital, Paediatric services in the months prior to her death but her condition was not diagnosed or recognised prior to death.
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. —
	At the inquest the Paediatric Expert, gave the opinion that
	The routine use of respiratory rate bench-markers in paediatric respiratory medicine The routine use of respiratory rate bench-markers in paediatric respiratory medicine.
	 The use of routine oxygen blood monitoring in paediatric medicine The recognition and action on red flag markers (which in this case were shortness of breath, chest pain and blue lips)
	Would have assisted and improved the chances of diagnosis and treatment of Esmee and other children, with a view to preventing future deaths or providing

appropriate treatment and palliative care in life limiting cases. **ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action. And that you are undertaking your own reviews and investigations into this death with a view to Local and Nationwide learning. In order to assist (with the consent RCHT and St Agnes Surgery) I attach St Agnes surgery root cause analysis incident no 2015#24302 Royal Cornwall Hospital, Treliske, Truro Serious Incident Report 2015/24302 YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by the 22nd July 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. **COPIES and PUBLICATION** 8 I have sent a copy of my report to the Chief Coroner and to the following Interested Royal Cornwall Hospital, of St Agnes Surgery and to the LOCAL SAFEGUARDING BOARD. I have also sent it to (Expert Paediatrician) 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. [SIGNED BY CORONER] 9 [DATE] Euzabetti Emma Caryon 27.05.2016