REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

- 1. President, Royal College of Paediatrics and Child Health, 5-
- 11 Theoboalds Road, WC1 8SH
- 2. Mr Gordon Miles, Chief Executive, Royal College of Emergency Medicine,
- 7-9 Bream's Buildings, Chancery Lane, London EC4A 1DT

1 CORONER

I am Andrew Harris, Senior Coroner, London Inner South jurisdiction

2 CORONER'S LEGAL POWERS

I make this report under paragraph 7, Schedule 5, Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

3 INQUEST

On 16th December 2016, I opened an inquest into the death of: Master Peter Kollar who died aged 3 ½, on 14th May 2015 at King's College Hospital (01351-15) (MM)

It was concluded on 6th June 2017. The medical cause of death was:

- 1a Multi-organ failure with pulmonary haemorrhage
- 1b Acute liver failure
- 1c Unidentified inborn error of metabolism
- II Viral infections

The conclusion was natural causes.

4 CIRCUMSTANCES OF THE DEATH

The child presented to A&E in a local hospital with diarrhoea and jaundice. He was diagnosed by a locum paediatric registrar with carotenemia despite his parents evidence that he disliked carrots. He was not admitted and sent home against the wishes of his parents, without a blood test or any investigation. He was not escalated for opinion by a consultant and one of the reasons was a normal Paediatric Early Warning Score (PEWS).

5 CORONER'S CONCERNS

During the course of the inquest, the evidence revealed a matter giving rise to concern that in my opinion means that there is still a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The MATTER OF CONCERN is as follows. -

Professor of Paediatric Hepatology, Birmingham gave an expert opinion. She said that jaundice is rare in children after the neonatal period and that its seriousness was under recognised by both paediatricians and emergency doctors. She considered that, whilst it made no difference to the

outcome in this case, the non escalation of a young child with jaundice to a suitable specialist adversely affects their care and is potentially life threatening. There will be instances when a child presents with a primary liver cause of hepatic failure where prompt referral for support and the possibility of organ transplantation was critical.

6 ACTION SHOULD BE TAKEN

recommended that your joint Royal Colleges should be notified of the risk of future deaths occurring through under recognition of the seriousness of jaundice and her recommendation that jaundice should be added to the Paediatric Early Warning Score as a matter requiring immediate escalation.

7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by Wednesday, 22 November 2017. 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.

If you require any further information or assistance about the case, please contact the case officer,

8 | COPIES and PUBLICATION

I have sent a copy of my report to the following Interested Persons:

(parents)

A&E consultant Royal Berkshire Hospital

I am also sending this report to the following, who may have an interest:

Department of Health

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 [DATE]

[SIGNED BY CORONER]

27-9-17