REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Chief Executive, Betsi Cadwaladr University Health Board**
1	**CORONER** I am David Lewis, Assistant Coroner, for the coroner area of North Wales (East and Central)
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 25th March 2013 HM Senior Coroner commenced an investigation into the death of Kate Louise Pierce ('Kate'). The investigation concluded at the end of the inquest on 22 September 2017, which was heard by me sitting with a jury. The jury's conclusion of the inquest was that Kate died from natural causes to which neglect contributed. The medical cause of death was: 1 (a) Acquired cerebral palsy with epilepsy and chronic lung disease 1 (b) complications of pneumococcal meningitis
4	**CIRCUMSTANCES OF THE DEATH** On 29 March 2006 Kate was unwell, presenting with a range of non-specific symptoms. The out-of-hours GP on the telephone advised that she should be seen in person by the out-of-hours GP. In turn, after examining Kate at the surgery, the latter referred her on to Wrexham Maelor Hospital for further assessment. She was seen first by a Paediatric Nurse and a short time later by a Senior House Officer. The latter diagnosed viral tonsillitis. The jury found that Kate had remained asleep and did not respond throughout the doctor's examination. Kate's parents believed that the junior doctor had taken a second opinion from a senior colleague (which supported the junior doctor's diagnosis) before Kate was discharged at about midnight on 29/30 March 2006, with an offer of 24/7 open access back to the department should her condition deteriorate. Following a deterioration in Kate's condition her parents returned her to the hospital at around midday on 31 March 2006, about 36 hours later. Thereafter it was quickly determined that she had developed pneumococcal meningitis. She was transferred for specialist care at Alder Hey Hospital, where tests confirmed the diagnosis and also revealed that she had Para-Influenza Virus Type III (which was likely to have been present on the evening of 29 March and may have been responsible for some of her symptoms at the time of her first presentation).

	As a result of the meningitis Kate suffered brain damage and other health conditions which persisted throughout her short life and were responsible for her death, in Florida, on 19 March 2013. Kate's death did not result in any formal or meaningful investigation by the Hospital until after it had received a letter of complaint from Kate's family some months after the events in March 2006. This delay compromised the quality and reliability of the memory of witnesses
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. I do so having taken into account the contents of written submissions sent to me by and on behalf of the Health Board on 4 October 2017. The **MATTERS OF CONCERN** are as follows. – (1) There remains uncertainty about the circumstances in which a sick child should be seen by a senior Paediatrician (Registrar or above) prior to discharge. During the hearing I was shown a document headed '*Guidance to Paediatric Junior Doctors on Discharge* [sic] *Children From Assessment Unit*', which I was given to understand reflects current practice and represents an improvement on the positon in 2006. The information in the letter of 4 October 2017 is broadly consistent with it. Both documents are silent as to whether a parental request for a second opinion should automatically lead to an examination of the child by the senior doctor. as was opined in court, where the importance and significance of parents' views were noted. . I am concerned that a lack of clarity about the Health Board's expectations in this respect may continue to allow for the possibility of a child being discharged without a sufficient (and sufficiently senior) assessment having be made. (2) I heard evidence at length from the Health Board's current Clinical Lead for Paediatrics about (inter alia) the measures which are in place to ensure that lessons can be learnt (and acted upon) promptly when things do not go to plan. Specifically I heard about steps taken to learn lessons from situations in which a child might re-present in a worse condition following an earlier discharge – a situation which might result from a missed diagnosis. I did not emerge from this evidence with any confidence that there exist clearly defined and consistently applied criteria from ensuring that learning opportunities are being actively sought out and acted upon. For example, I was told that there is no defined list of triggers; with much left to judgement of individuals in the senior management team. This evidence, supplemented by the relevant contents of the letter of 4 October 2017, leaves me concerned that too much is left to chance in the identification of matters requiring investigation; in the selection of the investigating staff and in the urgency of lessons being learnt and acted upon. The current system might therefore warrant a review (perhaps including consideration of best practice elsewhere, in other hospitals outside the Health Board) to see whether grounds for improvement exist.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 26th December 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to [redacted] (Kate's parents 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] 31.10.17** **[SIGNED BY CORONER]**