REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **The Chief Executive Doncaster and Bassetlaw Hospitals NHS Trust (The Trust)** 2. **The Chief Executive Bassetlaw Clinical Commissioning Group (CCG)** 3. **The Care Quality Commission (CQC)**
1	**CORONER** I am Dr Elizabeth Didcock, Assistant Coroner, for the Coroner area of Nottinghamshire
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 the 3rd March 2016, I commenced an investigation into the death of James Allbones, aged five years. The investigation concluded at the end of the inquest on the 2nd June 2017. The conclusion of the inquest was a Narrative as follows: James David Allbones died on the 2nd March 2016 at Bassetlaw Hospital from sepsis caused by Influenza B virus infection. He may also have had an additional bacterial infection. The guidelines for the management of sepsis were not followed.
4	**CIRCUMSTANCES OF THE DEATH** James died from sepsis at Bassetlaw Hospital, Nottinghamshire, within 12 hours of admission. He had been unwell in the days prior to admission, with a cough and breathlessness. The seriousness of his condition was not recognised, and the fluid management required as part of sepsis treatment was not given. There was very limited Consultant management and review of James' condition, and no early senior consideration of whether James should have been transferred out to another hospital that could provide Paediatric Intensive Care. Further detail of my findings in relation to these issues is included in the written judgment in this case, which is attached to this document. .
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 therefore my statutory duty to report to you. Essentially the serious and outstanding matters of concern are as follows: • That a child as ill as James will again be moved from the Emergency Department to the ward or Assessment Unit at the Hospital, rather than being transferred out for ongoing care – there is no reassurance that a sick child will be seen by a Consultant Paediatrician in the Emergency Department to assist with this decision • That the 'red flag' signs of sepsis will not be recognized and acted upon by the Paediatric team unless there is further training and awareness raising. I suggest The Paediatric Consultant team access external training and mentoring by

	senior colleagues ideally within their Critical Care network. • that there is still no protocol for face to face medical handover • that the Consultant team have rejected a model of care that encourages frank discussion with nursing and other staff on the ward, aimed at helping all staff speak up when worried about a deteriorating child (the RCPCH SAFE model) • the level of Paediatric staffing at Bassetlaw Hospital. I understand there is often only one junior doctor available, and that the middle grade doctor is on duty for 24 hours.
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 the 22nd September 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. For the avoidance of doubt, I will require a response from both the Trust and the CCG in relation to all concerns as above. I will require a response from the CQC setting out the findings of their recent inspection of the Paediatric Department at Bassetlaw Hospital, and plans to re – review in the light of this case. The Trust and the CCG may consider it advantageous to consider some of these issues jointly as well as individually. Should respondents favour supplementing their individual responses to all the above issues with a joint response, such a collaborative approach would be greatly welcomed but there is of course no obligation to do so.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: [redacted] James' parents [redacted] Chief Executive Sheffield Childrens NHS Foundation Trust (EMBRACE transport service) [redacted] Consultant Paediatrician, External Reviewer 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	**21st July 2017** **Dr E A Didcock**