REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Chief Executive of NHS England, Chief Investigating Officer for the Healthcare Safety Investigation Branch, Secretary Of State for Health, Secretary of State for business and the Chief Executive for the Royal Society for Prevention of Accidents.
1	CORONER I am Alison Mutch, Senior Coroner, for the coroner area of South Manchester
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 14th July 2017 I commenced an investigation into the death of Venkata Naga Lakshyasri KAGGA. The investigation concluded on the 28th February2018 and the conclusion was one of: Narrative: Died on 9th July 2017 from the recognised complications of an accidental ingestion of a button battery prior to 30th June 2017. She had been unwell in the intervening period and was seen on 4 occasions by doctors and on one occasion by ambulance staff but the presence of the battery was not established until post mortem. The medical cause of death was; 1a) Haemorrhagic shock due to massive hematemesis; 1b) Oesophageal arterial fistula on a background of an aberrant right subclavian artery; 1c) Oesophageal erosion from swallowed battery
4	CIRCUMSTANCES OF THE DEATH On 30th June 2017 at 01:14 hours, Venkata Kagga's parents were concerned about her health and called the 111 service. The call was referred to the out of hours service and advice was given to her parents. On 1st July 2017 her parents remained concerned about her and a further call was made to the 111 service. She was referred to the out of hours GP service. On 1st July 2017 at 13:36 she saw a GP who examined her and referred her to the paediatric assessment unit (POAU) at Wythenshawe Hospital. At the unit she was examined by a paediatrician who diagnosed tonsillitis and discharged with antibiotics. On 6th July 2017 her parents took her to see a GP concerned about health. The GP

	examined her and was concerned about the seven day history of temperature. She referred her to the POAU at Wythenshawe hospital. At 17:20 Venkata and her family arrived at the POAU. The booking in process was not followed. Observations were not taken. The medical records were not completed. Venkata was not examined. The Doctor spoke with Venkata's father and decided to issue a further prescription for antibiotics without examining Venkata. The documentation stated that she could not get the antibiotics from the GP. This is not what was recorded in the GP letter. Venkata and her family returned home. On 9th July 2017 at 09:44, her father called 999. He called because his daughter had reported being unable to see. An ambulance was dispatched. The crew arrived at 09:54 hours. Venkata was lying on a mattress with her mother. The crew carried out a limited assessment of Venkata. North West Ambulance Service (NWAS) policy requires all under 5's to be taken to hospital for specialist assessment. This did not happen. At 18:13 on 9th July 2017 a 999 call was made. At 18:18 North West Ambulance Service staff were at the scene. Venkata was making no respiratory effort and there was no palpable pulse. She was transferred to Stepping Hill Hospital where attempts to resuscitate her were unsuccessful. Post mortem examination showed that a button battery was lodged in her oesophagus and had eroded the oesophageal wall causing an oesophageal arterial fistula leading to her death.
5	<u>CORONER'S CONCERNS</u> 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. The button battery was likely to have come from a remote control. Button batteries once ingested can lead to catastrophic consequences for a child. They are used with increasing frequency in every day household devices which are often easily accessible by children. The remote control had no safety feature to prevent a child having easy access to the battery without the parents knowledge. Risks of button batteries to small children are not widely understood. Whilst there are precautions in place for children's toys similar precautions are not in place for commonly used household devices, which can easily be accessed by small children. 2. NHS England issued a safety alert across the NHS in December 2014 relating to button batteries. During the inquest it was clear that the impact of that alert had lessened over time across the Trusts involved. The Trusts involved in the inquest had taken steps to highlight and reinforce the safety alert amongst their workforce but no such national work had taken place.

	3. NWAS had a policy in place in relation to children under 5 that was not followed. Work had been carried out within NWAS subsequent to the death to reinforce the importance of young children been seen by paediatricians. Similar work had not occurred nationally. 4. The Hospital's POAU did not follow their system on 6th July and the Doctor on 6th July did not undertake an examination. This was not picked up by the Trust until an internal investigation post death. There was not at the time an audit system in place to ensure that systems in the POAU were being complied with. It is unclear if other POAUs will have audit systems to allow them to pick up on noncompliance with a recognised system. 5. The importance of carrying out a full assessment of a child or documenting fully why it was not carried out on 6th July was not recognised by the medical staff involved. 6. NWAS staff partly based decision making on 9th July on subjective assessment, which was not value checked with those who knew Venkata. The risks around subjective assessments particularly with young children with no basis on which to make a value comparison did not appear to be fully understood 7. The 111 service obtained detailed accounts of the history of illness. However systems for sharing information across the NHS are such that this information was not shared beyond the OOH GP service.
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 2nd May 2018. 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 namely , [redacted] father of the deceased 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.
9	Alison Mutch OBE

	HMC Senior Coroner 07/03/2018