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, Secretary of State for Health.
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 5th June 2017 I commenced an investigation into the death of Alfie Scambler-Holt. The investigation concluded on the 8th May 2018 and the conclusion was one of; **Narrative: Died as a consequence of an overwhelming infection on a background of cerebral palsy.** The medical cause of death was; **1a Sepsis; 1b Respiratory Tract Infection; II Cerebral Palsy**
4	Alfie Scambler-Holt had cerebral palsy and complex health needs as a result. On 3rd June 2017, just after 10.00, his mother went in to his bedroom and found he was very unwell. He had been well at 03.00. An ambulance was called and arrived within 10 minutes. Sepsis was suspected and he was transferred to Stepping Hill Hospital. Stepping Hill Hospital were on standby for his arrival. He was treated for suspected sepsis. His PEWS score was 8. The initial intravenous access tissued out after 50ml of fluid had been administered. Repeated unsuccessful attempts over an hour were made to gain access before the doctors were successful and antibiotics could be administered. He was transferred to the Paediatric Unit. His care was supervised by the registrar. He was not seen by a consultant. His PEWS score was 6 and his blood gas results showed high lactate and sodium levels indicating kidney compromise. He was treated with fluid boluses being administered. Fluid output levels were monitored through nappies rather than catheterisation. His PEWS score dropped to 4. His blood gas results remained high. A discussion with the on call consultant resulted to the agreement on the management plan. A consultant review in person was not carried out. At 20.00 on 3rd June 2017 his PEWS score rose to 6 and he was examined by the Registrar who prescribed a saline nebuliser in addition to the fluids prescribed. A 21.05, he suddenly stopped breathing. A prolonged attempt to resuscitate him was unsuccessful and he died at Stepping Hill Hospital on 3rd June 2018 from sepsis - 11 hours after his admission.

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. – The inquest heard that since the death of Alfie Scambler -Holt the Trust had done a significant amount of work looking at PEWS scores and escalation processes. The Clinical Lead for Paediatrics told the inquest that one of the challenges was that there was no national PEWS scoring system. As a result there were different PEWS scoring systems in operation in different trusts. This meant that staff dealing with children and moving/rotating between Trusts would not necessarily be dealing with the same system and escalation processes.
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 16th July 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] mother 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** **HM Senior Coroner** **21/05/2018**