Eastern Area of Greater London Coroners

MISS N PERSAUD

SENIOR CORONER

Walthamstow Coroner's Court Queens Road Walthamstow E17 8QP

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REF:6056

6th June 2018

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Alwen Williams, Chief Executive, Barts Health NHS Trust**
1	**CORONER** I am Miss N Persaud Senior Coroner for **Eastern Area of Greater London**
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 15/06/2017 I commenced an investigation into the death of William George BARTRAM. The investigation concluded at the end of the inquest 6th June 2018. The conclusion of the inquest was that William died as a result of natural causes, contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** William Bartram was born on the 24 February 2017. He was noted to have a chordee (kink in his penis and a hydrocele). Shortly after his birth, his mother noted that he was not producing a full urine stream and was only dribbling urine. A creatinine result taken on the 25 February 2017 was raised, but this was not noted or acted upon by any of the clinical staff. [redacted] (a qualified nurse), mentioned her concerns about lack of urine stream to a number of members of staff whilst she was in hospital. A routine referral was made to urology for review of the chordee. William was discharged from hospital on 27 February 2017. On 2 March 2017, William was taken to A&E due to concerns about weight loss and jaundice. A capillary blood gas taken in A&E on the 2 March 2017 showed a very high creatinine level of 155. This was not noted or acted upon by the clinical team. William's bilirubin level was noted to be near to the treatment line, so his parents were asked to return him to hospital the following day for a repeat bilirubin. William was returned to hospital the following day. His bilirubin was now above the treatment line, but it does not appear that this result was noted by any hospital staff. William should have been re-admitted to hospital on the 3 March 2017, but no action was taken to recall him. On the 10 March 2017, [redacted] raised her concerns with her General Practitioner. The General Practitioner was concerned by the history of dribbling urine. She was concerned that this might be causing back pressure on William's kidneys. She contacted the paediatric on call doctor who did not consider that William needed to be assessed in hospital. William should have been assessed in hospital, on the basis of the concerns raised by the General Practitioner on the 10 March 2017. William was taken to hospital on

	the 11 March 2017 as he was not feeding well and he was very grizzly. He deteriorated in A&E and despite all efforts at both Whipps Cross Hospital and the Evelina Hospital, he passed away from septic shock on 12 March 2017. Had William been assessed and investigated for urinary tract abnormality at any point up to and including 10 March 2017, it is likely that he would not have died from overwhelming sepsis on 12 March 2017. The abnormal blood results and concerns raised by William's parents, should have resulted in urinary tract investigations taking place prior to 11 March 2017.
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. – (1) The Trust's investigation report noted that on the 2 March 2017, the parents should not have been advised to attend outpatients for repeat bloods. They should have been advised to return to the emergency department. The A&E registrar who gave evidence during the course of the Inquest, confirmed that staff are not advised to ensure that babies return to the emergency department for repeat bloods. The process for repeat samples is not clear. A clear process for the taking of repeat blood samples for babies would be helpful. A process which would maximise the chances of the results being checked and actioned would be most desirable. (2) A grossly raised creatinine was found on a capillary blood gas sample taken in A&E on 2 March 2017. It was not noted by the clinical staff. It does not appear that the print out from the machine highlighted the result in any way. If abnormal results could be highlighted to clinical staff, this may reduce the risk of abnormal readings being missed. (3) Mr and [redacted] did not receive clear advice as to what to look out for, in terms of a healthy urine stream. Advice to parents on the discharge of babies from hospital, would be helpful. Mr and [redacted] accepted reassurance from staff, as they were unclear as to what was "normal".

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, [redacted] 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 3 August 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 Mr and [redacted] and the Child Death Overview Panel. I have also sent it to the Care Quality Commission and to Mr Matthew Cole (Director of Public Health), 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	06/06/2018 Signature Miss N Persaud Senior Coroner **Eastern Area of Greater London**