Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

NOTE: This from is to be used **after** an inquest.

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1 ……CEO Public Health England……
2 ……NHS111……
3 ……Herts Urgent Care Limited……

1 CORONER

I am Rosamund Rhodes-Kemp, Assistant Coroner for the area of Cambridgeshire and Peterborough

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 28/08/2015 I commenced an investigation into the death of Myla DEVIREN aged 2. The investigation concluded at the end of the inquest on 19/07/2019. The conclusion of the inquest was:

1a Small intestinal infarction

1b Small Intestinal Volvulus

1c Congenital intestinal malrotation

II

4 CIRCUMSTANCES OF THE DEATH

27th August 2017
Peterborough City Hospital Edith Cavell Campus Bretton Gate Peterborough

Myla Deviren (DOB 20.08.13). had congenital intestinal malrotation and developed a volvulus at approximately midnight on 26th August 2015. Her mother checked the NHS Symptom finder on line and the advice was to take her to A/E but she called 111 for advice.

04.06 The Health Assistant who took the call did not appreciate the significance of key symptoms due to multiplicity of symptoms described at the outset.

04.21 He passed the caller on a " warm" transfer to the Clinical Adviser whose initial reaction on hearing that the symptoms included blue lips and breathlessness was to call an ambulance, ignored her instincts and took mum through a series of digital pathways re lesser symptoms. When directly asking re the breathlessness and mum put the phone close to her daughter enabling the Clinical Adviser to hear the rapid breathing herself the latter did not appreciate the significance of it and did not call an ambulance.

04.55 She did however pass the call to the Out Of Hours Nurse who decided that this was a case of gastroenteritis early in the call and did not appreciate the description of a child with worsening signs –she said herself that she should have sent Myla down to the GP on duty at the Out Of Hours Centre.

She did not do so. Instead she gave worsening advice and terminated the call.

Whilst the precise point at which Myla stopped breathing is not known it was sometime between when she was last seen alive approximately 06.00 and then found unresponsive at 08.00 on the 27th August 2015.

She was then taken by ambulance to Peterborough City Hospital where, despite attempts at Resuscitation, she did not recover a heartbeat and was pronounced dead at 08.53.

Post mortem revealed small bowel infarction from untreated small intestinal volvulus.

It is probable that with earlier transfer to hospital by ambulance and with appropriate treatment M D would have survived.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows:

Children-particularly small infants do not present like adults when they are very unwell. Nor can they articulate their symptoms in a way that lends itself to prescribed pathway questions and answers and they are not in front of the staff handling the calls who therefore rely on parents for information.

Whilst since this event there have been steps to provide training of staff at 111 and Out of Hours services and NHS Digital have reworked the pathways to deal with multiplicity of symptoms there are still concerns re what further steps may be taken regrading cases involving children and infants. Evidence given at the Inquest was that about 20% of calls to both services relate to sick children. There should therefore be robust systems in place to prevent sick children going without potentially lifesaving treatment.
Steps should include:

1. Mandatory annual training for all staff on recognising and interpreting signs and symptoms for all staff taking calls needs to be put in place.

2. A suitably qualified paediatric specialist clinician should be available to discuss or review such cases at all times.

3. The default position and precautionary advice should be- if in doubt call an ambulance.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 **19 November 2019**. 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
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and to the Local Safeguarding Board (where the deceased was 18). I have also sent it to
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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.

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Rosamund Rhodes-Kemp

Rosamund Henrietta Duncan Rhodes-Kemp
Assistant Coroner
for Cambridgeshire and Peterborough
Dated: 24.09.19