Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

Southport and Ormskirk Hospital NHS Trust
Southport and Formby District General Hospital
Town Lane, Kew
Southport, Merseyside
PR8 6PN

1 CORONER

I am Andre REBELLO, Senior Coroner for the area of Liverpool and Wirral

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 21/01/2020 I commenced an investigation into the death of Eva Hayden aged 4. The investigation concluded at the end of the inquest on 07 May 2021. The **cause of death** found was:
I a Sepsis
I b
I c
II Bone Marrow Hypoplasia

The **conclusion** of the inquest was:

Eva Hayden died from natural causes, in part because it was not appreciated that she suffered from neutropenia. There were missed opportunities in the investigation of the neutropenia.

4 CIRCUMSTANCES OF THE DEATH

Eva Hayden was 4yrs old and lived at home with her parents and two siblings. In October 2019 Eva had left ankle cellulitis and pancytopenia. She presented to Ormskirk hospital on 19th October with symptoms of a fever, difficulty in weight bearing and left ankle swelling. She was transferred to Alder Hey Children's' Hospital on 20th October for further management and treatment by the orthopaedic team. Eva was subsequently discharged home on oral antibiotics on 23rd October. A plan remained in place with Ormskirk Hospital in relation to the diagnosis of pancytopenia, which was believed to be secondary to infection. Eva attended at Ormskirk hospital for her blood to be tested to monitor her pancytopenia. She attended for bloods to be taken on the 4th, 8th and 18th November 2019. Over this time her haemoglobin and platelets improved but she still suffered from neutropenia. On the 25th November 2019 her next full blood count appointment was missed. There was no follow-up by Ormskirk hospital as erroneously it was assumed that follow up treatment for haematology was being conducted at Alder Hey, when she was seeing Alder Hey only for her cellulitis and possible bone infection and joint infection. This was a missed opportunity to diagnose and treat the underlying cause of the neutropenia.

To compound the situation there was never appropriate communication to Eva's parents as to the meaning of neutropenia with regard to her susceptibility to infection, and the importance of seeking urgent and appropriate medical attention for signs of infection.

Eva was unwell during in the first week of 2020 with fever like symptoms and was taken to an NHS walk in centre on Wednesday 8th January by her Mum. Advice was given to take Eva to Alder Hey where she was then further examined and discharged in the early hours the following day. It was not appreciated by the emergency team at Alder Hey or indeed by Eva's parents that she suffered from neutropenia and she was managed for a viral infection.

On 10th January 2020, Eva was profoundly unwell and advice was received from NHS 111 to urgently contact primary care. There were no doctors available and advice was given to ring for an ambulance. However, Eva's condition improved. Later the same day after collapse Eva was taken to Alder Hey Emergency department by ambulance after Eva's dad had commenced CPR, which was continued by paramedics. Eva's death was confirmed 06:58 on 11th January 2020 in the emergency department. It was only after death that bone marrow histology revealed hypoplasia which may have been caused by infection but the aetiology of which remains unclear.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows: (brief summary of matters of concern)

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.

a) When investigating, diagnosing or treating a patient's presentation it seems reasonable that there should be good communication between clinician and patient with regard to the treatment plan. Understanding of the patient should be confirmed with regard to any precautions or risks arising from the condition. In this matter, Eva's parents had no knowledge of the pancytopenia or neutropenia under investigation and the risks of infection for Eva – such that this was not explained to the staff in the Emergency department at Alder Hey on 8th January 2020. Clinical practice should have prevented this eventuality.

b) When Eva missed the appointment at Ormskirk Hospital on the 25th November 2019 for her blood tests – there was no follow up by the hospital as there was an "assumption" that a follow-up orthopaedic appointment for cellulitis would investigate her neutropenia. The assumption was wrong and there was no clinical communication between the Trusts, which would have clarified that investigation of neutropenia had ceased without resolution. The onus for investigations cannot be on a four year old or her parents who were unaware of the potentially fatal implications.

What systems and training have been put in place to avoid a repetition of (a) & (b)?

7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 03 July 2021. I, the coroner, may extend the period.

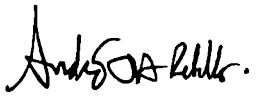
Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.

8 COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons
Eva's family
Alder Hey NHS Foundation Trust
NHS 111 - NWAS
and to the Local Safeguarding Board (where the deceased was 18). I have also sent it to
NHS Improvement
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.



Andre REBELLO
Senior Coroner for
Liverpool and Wirral
Dated: 09 May 2021