Regulation 28: Prevention of Future Deaths report

Martha Poppy MILLS (died 31.08.21)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Chief Executive** **King's College Hospital NHS Foundation Trust** **Denmark Hill** **London SE5 9RS**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 3 September 2021, one of my assistant coroners, Jonathan Stevens, commenced an investigation into the death of Martha Mills, aged 13 years. The investigation concluded at the end of the inquest on Friday, 25 February 2022. I made a narrative determination (copy attached).
4	**CIRCUMSTANCES OF THE DEATH** Martha sustained a handlebar injury whilst cycling on a family holiday in Wales. She was transferred to King's College Hospital London and died approximately one month later. Her medical cause of death was: 1a refractory shock 1b sepsis 1c pancreatic transection (operated) 1d abdominal trauma

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. As you will see from the attached narrative conclusion, whilst at King's Martha was not referred to the paediatric intensivists promptly. If she had been referred promptly and had been appropriately treated, the likelihood is that she would have survived her injuries. 1. I heard that the bedside paediatric early warning score (BPEWS) system at King's is currently still paper based, unlike the adult system. It was put to me very forcefully by medical staff that, until the PEWS system moves to an electronic base as part of electronic recording of the paediatric records as a whole, monitoring and care of children may be sub optimal, with a higher risk of this sort of situation recurring. 2. The King's serious incident investigation identified that Martha's care fell down between the paediatric hepatologists and the paediatric intensivists. I heard evidence that it is the intention of King's to improve the formal relationship between the hepatology and the paediatric intensive care departments, and to ensure that there is pro-active paediatric intensive care outreach. However, the intended programme has stalled, I think partly because of the pandemic. It seems that there needs to be an impetus for this to be re-started and to gain sufficient momentum to operate smoothly in the future.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 25 April 2022. 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 following. • [redacted], Martha's parents • Care Quality Commission for England • HHJ Thomas Teague QC, the Chief Coroner of England & Wales I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**DATE** **SIGNED BY SENIOR CORONER** 28.02.22 *ME Hassell*