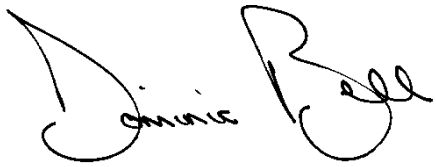
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Dr [redacted], President, Royal College of Paediatrics and Child Health 2. [redacted], President, Royal College of General Practitioners 3. Dr [redacted], Chief Clinical Officer for NHS Pathways, NHS Digital
1	**CORONER** I am MD Dominic Bell, Assistant Coroner, for the Coronial area of Hull and the East Riding of Yorkshire
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 10 May 2019 I commenced an investigation into the death of Esma GUZEL aged 5 years. The investigation concluded at the end of the inquest on 23 March 2022. The conclusion of the inquest was in narrative format as follows: *Esma Guzel died on 10 May 2019 aged five years, due to complications of incarceration of a segment of small-bowel within the chest via a congenital diaphragmatic hernia. The presence of this condition was not identifiable by any features in her early years until the onset of vomiting and abdominal pain approximately 24 hours prior to her death. Esma was brought for a GP assessment by her mother on the afternoon of 9 May 2019, which culminated in the working diagnosis of a 'tummy bug/gastroenteritis'. Treatment with an electrolyte solution was prescribed to avoid dehydration and a safety net arrangement established in the event of any worsening of her condition. Following a deterioration, a call was placed to 111 services, which triggered the advice to attend an out of hours GP service in Beverley. Esma was transported there by her father, but at the point of arrival approximately 40 minutes later was found to be in a state of cardiac arrest from which Esma could not be resuscitated. On the balance of probability, Esma would have survived this critical illness if for whatever reason and by whatever route, she had been admitted to hospital following the GP assessment.*
4	**CIRCUMSTANCES OF THE DEATH** See above narrative and enclosed 'summing up and conclusions' dated 23 March 2022.

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. – I have been presented with evidence prior to and at inquest, that diligent questioning as to the nature of vomitus in a five-year-old patient, would have alerted a competent practitioner to the requirement for urgent hospitalisation. The facts of this case are that with the child continuing to be unwell eight hours later, the 111 algorithm led to her being driven by her father to an out-of-hours GP run service with no accessible paediatric infrastructure, where she arrived in a state of cardiac arrest. The 111 algorithm has been subject to modification in the light of these events, but I remain concerned that there is no detailed assessment of the degree of parental concern, no accommodation of the prior direct review by a general practitioner, and no consideration of the timing of the request for advice, when reaching a disposition that does not involve referral to paediatric services. It is difficult to reconcile professional opinion that this patient should have been referred to paediatric services on the basis of features at 5 PM but not in the small hours of the morning with a deterioration in her condition by that stage. I have heard in evidence that an educational message on 'rare causes for common symptoms' could be circulated as a case report, but take the view that the lead professional bodies for both general practice and child health should consider how such information is effectively disseminated, and whether the algorithms and dispositions generated by the 111 service need further modification to maximise the chance of expedited optimal care for what is acknowledged to be an uncommon condition. I have heard in evidence that the 111 service is the default safety net arrangement in such circumstances, and this therefore requires endorsement by your professional bodies, if it is to command the confidence of patients, parents and practitioners as a definitive safety net.
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 27 July 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 Chief Coroner and to the following Interested Persons: • the family of Esma GUZEL • Dr [redacted] • Dr [redacted] Medical Director Yorkshire Ambulance Service • Dr [redacted] consultant paediatrician Hull Royal Infirmary I have also sent it to the following medical experts who may find it useful or of interest: • Dr [redacted] GP • Dr [redacted] consultant paediatrician • Mr [redacted] consultant paediatric surgeon

	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	**Dated: 1 June 2022**  **MDD Bell** **Assistant Coroner** **Hull and the East Riding of Yorkshire**