**ANNEX A**

**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)**

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

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br>**1. Sheffield Children's NHS Foundation Trust** |
| 1 | **CORONER**<br><br>I am Abigail Combes, assistant coroner, for the coroner area of South Yorkshire (West District) |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 13 October 2022 I commenced an investigation into the death of James Phillliskirk born on 11 January 2021. The investigation concluded at the end of the inquest on 24 April 2023. The conclusion of the inquest was:-<br><br>James was referred to hospital on 12 May 2022. Following a number of assessments in hospital, James was misdiagnosed and was not provided with treatment in line with departmental guidance. He developed sepsis and died at home on 13 May 2022. His death was contributed to by neglect.<br><br>The medical cause of death was:<br><br>1a: Sepsis<br>1b: Group A streptococcus skin infection |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>James had had chicken pox and recovered in April 2022. He returned to nursery and on 10 May 2022 nursery reported that James was more clingy than normal and seemed like he may be unwell. His parents monitored him and determined on 12 May 2022 that they would seek medical support. They saw the family GP who reviewed James, heard that there may have been exposure to Scarlett Fever at nursery and heard him make a groaning noise which concerned him so he sent James into Sheffield Children's Hospital A&E with his father.<br><br>James was seen by a triage nurse and a clinical fellow and a diagnosis of chicken pox was made. James had a lesion on his right wrist which ought to have been looked at more closely and the fact that he had recently had and recovered from chicken pox ought to have generated a senior review of his condition. James was sent home.<br><br>James' mother returned from work and felt that he was more unwell. As a result she sought support from 111 who spent some time speaking to James' mother and heard James groaning. They asked James' parents to take him into A&E within the hour but |

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| | the sooner the better for further assessment.<br><br>James returned to A&E with his mother and was reviewed by the same triage nurse. He was reviewed by a junior doctor who formed the view that the first episode of chicken pox must be a mis-diagnosis and he persisted with a diagnosis of chicken pox. Again, the fact that James had been brought back into A&E so soon and the suggestion of a reinfection with chicken pox should have generated a senior clinical review but it did not.<br><br>James was sent home and continued to be unwell that evening. His mother and father determined they would return the following day however James died at home in the night.<br><br>A post mortem revealed that he had developed sepsis.<br><br>I heard evidence from the Hospital that had James been sent into A&E through the usual GP referral route then he would have been triaged and seen in the medical unit which would have greater level of senior oversight, a different set of more detailed guidance for re infection with chicken pox and would have stayed for longer making it more likely that the groaning would have been heard. All of this would make it more likely that James would have lived.<br><br>There were however significant opportunities for James' condition to be identified in A&E notwithstanding this process change. It was also apparent in evidence that James should have had senior escalation and the lesion on his wrist should have been identified as being different from a normal presentation of chicken pox.<br><br>A&E hold a handbook which provides advice and guidance on a vast array of conditions which may be seen in A&E. This is inevitably not as detailed as the medical guidance issued to specialties at the hospital. Crucial sections of the specialist guidance were not easily identifiable in the A&E handbook including the need to seek senior advice in certain circumstances or identify the risks from recent reinfection of chicken pox. This guidance therefore was not able to influence decision making of clinicians looking after James in hospital. |
| 5 | **<u>CORONER'S CONCERNS</u>**<br><br>During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>1. Junior staff not knowing when to escalate concerns<br>2. Unclear guidance in the handbook relating to chicken pox and reinfection and the need for aggressive antibiotic treatment if reinfection occurs soon after the initial infection<br>3. Confirmation bias affecting clinical reviews<br>4. Lack of proper assessment of existing skin lesions in chicken pox even where identified by parents<br>5. Lack of knowledge of the risk of secondary complications from recent chicken pox infection in the emergency department<br>6. Insufficient weight on GP referral when not through the identified route of referral (ie presentation straight to A&E which amounts to 25% of referrals). I heard evidence that an IT system is in development to resolve this however engagement of NHS Digital and the Commissioners is required to progress. For the avoidance of doubt, had the GP referral been processed in the usual way James would have gone through to the medical unit and the result would have been senior oversight and a strong likelihood that James would have received IV antibiotics and survived. |

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| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe your organisation have the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 5 July 2023. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: [redacted] and Sheffield Children's NHS Foundation Trust.<br><br>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.<br><br>I may also send a copy of your response to any other person who I believe may find it useful or of interest. In this case I have sent a copy of this report to NHS England, NHS Digital and to NHS South Yorkshire ICB.<br><br>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.<br><br>You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response. |
| 9 | **10 May 2023** **ABIGAIL COMBES** |