REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted]**, Chief Inspector of General Practice, Care Quality Commission,** [redacted]
1	**CORONER** I am R Brittain, Assistant Coroner for Coventry.
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** Vanessa Ferkova died, aged 2, on 16 January 2017 from meningococcus septicaemia. The inquest into her death concluded on 26 January 2018; I recorded a narrative conclusion (see attached).
4	**CIRCUMSTANCES OF THE DEATH** Miss Ferkova had a non-significant medical history. She presented to Coventry GP Walk-in Centre at 2pm on 16 January 2017 with her parents, having suffered from fever and vomiting that morning. A receptionist took down details of her illness and recorded that Vanessa looked 'pale'. The information recorded did not meet the 'red or yellow flag' conditions which would have prompted prioritisation of her care. Her parents stated that Vanessa vomited in the waiting room which would have prompted prioritisation but they were not aware of this 'flag' and did not report this incident. Vanessa also developed a rash whilst waiting to be seen which, if 'non-blanching' would have also prioritised Vanessa assessment. Her parents' evidence was that the development of a rash was raised to the receptionist, although this was not her recollection of events. As such, there was no clinical assessment until Vanessa was seen by a nurse shortly after 4pm. At that time she was recognised to be very unwell and likely suffering from meningococcal septicaemia. She was given antibiotics and and an ambulance was called. In the ambulance, at shortly after 4.30pm, Vanessa went into cardiac arrest. Unsuccessful resuscitation attempts were made, including on arrival at hospital shortly after her arrest, and she died at 5.11pm. I heard evidence from the treating hospital paediatrician that it was likely Vanessa was suffering from compensated shock on her arrival at the walk-in centre and that, had observations been undertaken at this stage, this would have been recognised, treated and Vanessa would have survived. The paediatrician set out that recording clinical observations was a 'vital patient safety tool' in the secondary care setting. I heard from

	the walk-in centre provider that, unlike in the secondary care setting, they are not commissioned to undertake clinical triage and that nor is there a timeframe within which patients are required to be initially assessed.
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 heard evidence from the CQC that the walk-in centre had been inspected for the first time in the June following Vanessa's death. It was judged to have 'triage process whereby patients were assessed so they were seen according to clinical need…' but also that 'Patients arriving at the service were seen generally according to arrival time'. The report also states that 'Screening, prioritising and navigation of patients was completed by an appropriate clinician'. These conclusions were based on the process of receptionists documenting the presence/absence of 'red flags' and clinicians reviewing the waiting list when considering which patient was next to be seen. I am concerned that the CQC judged the centre to have a triage process that was based on clinical need when that assessment does not include taking clinical observations which, in secondary care hospitals, was stated to be a vital patient safety tool. Given that walk-in centres and emergency departments both accept 'unscreened' patients, it is concerning that such differing triage systems should be in place; a situation which is seemingly accepted by the regulator. I heard evidence that, should this circumstance repeat itself, then it is likely that the same outcome would occur. As such, my duty to raise these concerns is engaged.
6	**ACTION COULD BE TAKEN** In my opinion action could be taken to prevent future deaths and I believe that the addressee has 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 23 March 2018. 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, Miss Ferkova's family, NHS England and Virgin Care Limited. 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	26 January 2018  **Assistant Coroner R Brittain**