REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted]**, National Clinical Director for Urgent Care for NHS England, NHS England, PO Box 16738, Redditch, B97 9PT**
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 am concerned that there is a difference in the services commissioned between primary and secondary care settings, where the potential population of patients is similar; that being unscreened members of the public, including children. I heard evidence that there is a confusion amongst the general public as to the roles of walk-in centres, urgent care centres and GP services attached to Emergency Departments. In this case it was likely that, had Vanessa presented to a GP service attached to an Emergency Department, she would have had a clinical triage within 15 minutes of arriving (including an assessment of clinical observations) and that she would not have died from septicaemia. I am concerned that she did not receive this care because of the service from which her parents (understandably) sought treatment. The walk-in centre provider is currently investigating whether it should/could provide a triage service which includes an assessment of clinical observations. I am to be provided the outcome of this investigation at the end of February 2018. As such, I have not written a prevention of future deaths report to this provider but I am concerned that this is a nationwide issue which warrants consideration by NHS England as the commissioner of primary care services.
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, the CQC 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**