Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 National Institute for Health & Care Excellence (NICE)** **2 Royal College of Paediatrics and Child Health HEALTH POLICY**
1	**CORONER** I am Catherine WOOD, Assistant Coroner for the coroner area of Suffolk
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 11 April 2023 I commenced an investigation into the death of Nuel-Junior Kerlii DZERNJO aged 10. The investigation concluded at the end of the inquest on 30 November 2023. The conclusion of the inquest was that: Narrative Conclusion The medical cause of death was confirmed as: 1a Varicella Zoster Infection 1b Immunosuppression 1c Steroid Therapy
4	**CIRCUMSTANCES OF THE DEATH** Nuel-Junior Dzernjo was a ten year old boy who had been under investigation for a neurodegenerative condition having been noted to have seizures on an Electroencephalogram. There was no clear cause or diagnosis for the seizures but it was felt that he was suffering from electrical status epilepticus during slow-wave sleep. In November 2022 a decision was made to commence him on high dose steroids, a known consequence of which was immunosuppression. He developed signs of chicken pox on Friday 17 February 2023 and was brought to his community paediatric appointment on 20 February 2023 but not seen and assessed as he was known to have a contagious disease. He was seen later that day by a nurse at his general practitioner surgery and was seen and sent home. A later discussion between a general practitioner at the surgery and the community paediatrician led to a referral to the paediatric assessment unit at Ipswich hospital. The unit was busy and an appointment was not made until the following morning. By 11am on 21 February 2023 Nuel had deteriorated further and his parents had to support and carry him to the paediatric assessment unit arriving at 11.05am. Observations taken at 11.30am revealed he was pyrexial, tachycardic and tachypnoeic but the sepsis pathway was not followed. He was prescribed paracetamol at 12.15 and seen by a paediatric registrar who did not consider the sepsis protocol should be initiated as there was a clear cause for his symptoms i.e chicken pox. The plan was made to observe him, recheck his observations and if he had improved to send him home with oral Acyclovir. At 13.20 he remained pyrexial and tachycardic and his respiratory rate was still high at 32 and he was prescribed Ibuprofen. By 15.30 his

	temperature had come down and his heart rate had settled but was still high at 118, as was his respiratory rate at 29. He was also unable to mobilise having previously not being limited with his mobility. He was confused but this was considered to be his usual presentation due to his neurodegenerative condition. The doctor who planned to discharge him did not discuss him with a Consultant and was not aware he needed a wheelchair to leave hospital having had no issues with his mobility prior to the onset of his current viral illness. He was taken home by his parents and was unable to swallow his oral medication and took very little by way of fluids. He deteriorated the following day and collapsed shortly before 2pm. His parents called emergency services and police and paramedics attended. Despite attempts at resuscitation including in the emergency department at West Suffolk hospital he died later that afternoon. A post mortem revealed he had died as a consequence of Varicella Zoster.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) During the course of my investigation into the death of Nuel-Junior I instructed an independent paediatric expert to review his management and opine on causation. During the course of hearing the evidence from the expert and all of the treating clinicians it became clear that there was some potentially relevant guidance available but it lacked clarity. Here intravenous Acylovir, if prescribed, may have prevented Nuel-Junior's death but he was instead prescribed oral Acyclovir which was unlikely to have made a difference. Had clear guidance been available then Nuel-Junior's death may have been prevented.
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 February 12, 2024. 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 [redacted] I have also sent it to **West Suffolk NHS Foundation Trust (Legal Services)** **Ipswich and Colchester Hospital (Legal Services)** **Stowhealth (Violet Hill)** who may find it useful or of interest. 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: 18/12/2023** C Wood **Catherine WOOD** **Assistant Coroner for** **Suffolk**