REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Rt Hon Steve Barclay, Secretary of State for Health and Social Care** **2. [redacted], President of the Royal College of Paediatrics and Child Health** **3. [redacted], Chief Executive of National Institute for Health and Care Excellence**
	CORONER I am Joanne Kearsley, Senior Coroner for the Coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On the 30th January 2022, I commenced an investigation into the death of Sienna Daisy Barber, date of birth 27th May 2019 who died on the 29th January 2022 at the Royal Oldham hospital aged 2 years and 8 months old. The medical cause of her death was confirmed as 1a) Acute necrotising bronchopneumonia due to 1b) Group A Streptococcus.
4	**CIRCUMSTANCES OF DEATH** Sienna was a healthy child with no underlying medical conditions. On Sunday 23rd January she developed a high temperature. There were no specific concerns although it was noted she was eating less. The following day she was taken by her parents to her GP practice where she was examined and a suspicion of a viral infection was diagnosed. Parents were advised to continue with Calpol and to re-attend if there were any concerns. The next day Tuesday 25th January Sienna awoke and was more unwell, she had vomited and her temperature was 40.2. Parents sought advice from 111 who advised them to take her to A&E. Sienna was then taken to North Manchester General Hospital where she was triaged and examined. It was suspected Sienna had a viral respiratory tract infection, her throat was inflamed and whilst her temperature remained high, the advice was to take her home and continue with Calpol and ibuprofen. Over the next few days Sienna's temperature fluctuated. Whilst at times her temperature decreased, Sienna remained tired and lethargic and had a sore throat. On Saturday 29th January 2022, Sienna began to be very agitated, flinging her arms and legs around. She was taken immediately to Rochdale Urgent Care Centre. Upon arrival she began to present with mottling. She was immediately treated and transferred to Royal Oldham hospital where she died later that day.
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:- 1. The court heard evidence that since 2014 cases of Group A Streptococcus have increased annually. After Sienna's death in December 2022 there was a significant increase of cases in young children. Whilst emergency guidance was issued to practitioners in December 2022 this related to the threshold for the administration of treatment in cases where Group A Streptococcus. This guidance has itself now been withdrawn. **The court heard that unlike other conditions such as Meningitis there is no NICE guidance for practitioners to assist them with how to diagnose / treat Group A Streptococcus**. Apparently there has been previous consideration of this but a decision was taken not to provide such guidance. The court was advised this decision was taken having considered the impact of Group A Streptococcus on the whole of the population. However the court informed that there are three high risk groups, these being ; i) Children under the age of 5, ii) women who have given birth in the last month and iii) the over 75's. In my opinion consideration of guidance targeted towards these three high risk groups should be considered. 2. The court also heard that in 2019 a NICE publication considering rapid antigen testing was published. This did not recommend rapid antigen testing. However this publication excluded consideration of testing in the high risk group, the under 5's. Rapid antigen testing is carried out in other countries such as the USA and Canada. The court heard Sienna would have been entirely the sort of patient where such testing would have been appropriate on the 25th January 2022 when she was examined at North Manchester and she would have immediately been commenced on the treatment for Group A streptococcus, penicillin. In my opinion consideration should be given for rapid antigen testing in the under 5's in such cases.
W	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 **26th June 2023**. 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 namely:- The parents of Sienna Barber Manchester Foundation NHS Trust Greater Manchester Integrated Care Board 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 from. 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	Date 3rd May 2023 Signed: Meakley.