MISS N PERSAUD
HIS MAJESTY'S CORONER
EAST LONDON
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • [redacted], National Medical Director, NHS England [redacted]
1	**CORONER** I am Nadia Persaud Area Coroner for the coroner area of East London
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 14 June 2023 I commenced an investigation into the death of Isaac Onyeka (age 3 years old). The investigation concluded at the end of the inquest, on the 5 March 2024. The conclusion of the inquest was that Isaac died as a result of natural causes. The inquest heard that there were non-causal concerns in relation to the treatment provided to Isaac in the days leading up to his death.
4	**CIRCUMSTANCES OF THE DEATH** Isaac Onyeka was a 3-year-old boy, diagnosed with Down's Syndrome. On the 26 May 2023 Isaac showed the first signs of chicken pox. On the evening of 30 May 2023, Isaac's mother noted that Isaac had a painful swelling under his arm. She called NHS111 and spoke to a health adviser. On the basis of the information elicited through the use of the NHS 111 Pathways algorithm, an appropriate disposition was reached, for Isaac to be assessed by his general practitioner within 24 hours. The following morning,

	Isaac's mother was asked to provide a photograph of Isaac's swelling to the GP practice. She immediately uploaded a photograph of the swelling under the arm and also a swelling in the groin area. In addition, she provided important clinical detail with the photographs. An ST3 GP registrar viewed the photographs, but did not view the additional clinical information. The same GP registrar then spoke with Isaac's mother at around 1030am. Red and amber flags of sepsis were described to the GP registrar, but the clinical significance of these were missed. In assessing Isaac's risk of a serious infection, the GP registrar did not consider two applicable risk factors, namely the immune deficiency associated with Down's Syndrome and the raised risk of Group A streptococcal infection associated with chicken pox. Isaac should have been directed to hospital following the consultation. Instead, his mother was advised that the lymphadenopathy would likely self-resolve. During the afternoon of the 31 May 2023, Isaac became unresponsive in his home address. Resuscitation efforts were made by his mother, the ambulance service and the helicopter emergency medical service. Isaac was taken to Whipps Cross Hospital where sadly his life was pronounced extinct on 31 May 2023. Due to the fulminant nature of Group A streptococcal infection, had Isaac attended hospital during the morning of 31 May 2023, it is unlikely that his death would have been avoided. Hospital care would have been required during the evening of the 30 May 2023 for Isaac's death to have been avoided. Application of the current NHS 111 Pathways assessment did not capture all of the necessary background clinical detail, which could have resulted in the necessary hospital disposition on 30 May 2023.
5	**<u>CORONER'S CONCERNS</u>** 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. The **MATTERS OF CONCERN** are as follows: (1) There is concern that there is a knowledge gap amongst the public (parents of children with Down Syndrome in particular), and amongst some healthcare practitioners in relation to the immune deficiency associated with Down Syndrome. The paediatric independent expert stated that: *Down Syndrome is the most common genetic disorder associated with immune defects. Children with Down Syndrome need to be managed with a heightened sense of awareness in the setting of sepsis.* This was not however known by Isaac's parents or by the GP registrar. (2) Health advisers with NHS111 do not have access to GP electronic summaries. They do not therefore have the background diagnoses of the patient concerned. The inquest heard that a different disposition would have been reached, had the health adviser been aware of the diagnosis of Down Syndrome. Had the health adviser been aware of the diagnosis, Isaac would have been assessed by a clinician during the evening of the 30 May 2023. Had this happened, Isaac's death would have been avoided. (3) The inquest heard that there is no central resource for assisting families to recognise signs of sepsis in patients with darker skins.
	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 **7 May 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 to the Inquest, family of Isaac Onyeka, Forest Practice, Hertfordshire Urgent Care, to the Care Quality Commission and to the local Director of Public Health who may find it useful or of interest. 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. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**11 March 2024**