REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Chief Executive, Sherwood Forest Hsopitals NHS Foundation Trust**
1	**CORONER** I am Dr Elizabeth Didcock, Assistant Coroner, for the coroner area of Nottinghamshire
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 the 6th December 2022, I commenced an investigation into the death of Meha Carneiro. The investigation concluded at the end of the inquest on the 1st March 2024 The conclusion of the inquest was a narrative as follows: Meha Carneiro died at 14.28 hours on the 5th December 2022 at the age of 5 years and 7 months, from overwhelming sepsis caused by infection with Group A streptococcus. Meha had Down syndrome. The seriousness of her clinical condition was not recognised when she presented to Kings Mill Hospital on 5.12.22 at 07.39 hours. She was managed with oral fluids, and struggled to have more than a very minimal intake, she had continuing diarrhoea, and was not reviewed by a paediatrician, nor a senior doctor in the Emergency Department, as she should have been. She was not provided with intravenous fluids nor antibiotics as she should have been. The lack of repeated observations, the lack of review of the oral fluid challenge, the lack of senior review, leading to the lack of recognition of the seriousness of her condition, all probably made a more than minimal, negligible or trivial contribution to her death. Had intravenous fluids and antibiotics been provided in the morning of 5.12.22, she would on balance have survived. Her death was contributed to by neglect
4	**CIRCUMSTANCES OF THE DEATH** Meha died at Kings Mill Hospital on 5.12.22. She had Down syndrome, and was unwell with intermittent fever, cough, abdominal pain and diarrhoea and vomiting over the two to three days prior. She was brought to hospital on the morning of 5.12.22 by her father, and collapsed in cardiac arrest approximately five and a half hours after admission. She could not be resuscitated. Detailed Findings as to how she came by her death are provided in a written Determination dated 1.3.24, appended to this report .

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. There were insufficient trained Paediatric nurses on duty in the Emergency Department (ED), on the day of Meha's admission, and there was no effective escalation to senior nursing staff to highlight this 2. There was overall a lack of recognition of how unwell Meha was on admission and over the subsequent hours prior to her death- this included both nursing and medical staff in ED 3. Whilst switching from use of POPS to PEWS in ED, is likely to assist in ensuring repeat observations in a sick child, a PEWS of 6-8 only triggers review by a junior rather than a senior ED Doctor, the former less likely to recognise severity of illness and respond appropriately 4. There was insufficient and ineffective handover between medical staff, with lack of documentation of key information, and agreed clinical plans- between doctors in ED, and between ED and Paediatric staff I am not reassured that necessary actions to address these serious issues identified are in place.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe you 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 the **29th May 24**. 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: 1. Meha's family 2. The Care Quality Commission 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 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 by the Chief Coroner.
9	**3rd April 2024**  **Dr E A Didcock** **H M Assistant Coroner for Nottingham and Nottinghamshire**