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 Hospitals NHS Foundation Trust**
1	**CORONER** I am Dr Elizabeth Didcock, Assistant Coroner, for the coroner area of Nottingham and 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 8th December 2022, I commenced an investigation into the death of Tommy Jay Gillman The investigation concluded at the end of the inquest on the 15th March 2024 The conclusion of the inquest was a narrative as follows: Tommy died on 8.12.22 from sepsis and multi organ failure secondary to Salmonella Brandenburg meningitis. There were missed opportunities to provide him with earlier antibiotics, fluid resuscitation and intensive monitoring from 12.35pm on the 7th of December 2022 at Kings Mill Hospital. Once the severity of his illness had been recognised at approximately 1700 hours on that day, he was provided with prompt treatment for septic shock and meningitis. Sadly however he did not respond to this treatment and died the following day following transfer to Leicester Royal Infirmary. Whilst there were serious missed opportunities to provide earlier treatment of sepsis and meningitis, I cannot say that these issues of care have made a more than minimal negligible or trivial contribution to his death.
4	**CIRCUMSTANCES OF THE DEATH** Tommy died on 8.12.22 at Leicester Royal Infirmary. He had been transferred there from Kings Mill Hospital (KMH) the previous evening for intensive care management, having presented to the Emergency Department at KMH at 12.35 hours on 7.12.22. He was extremely unwell on presentation to KMH, but he was not treated with antibiotics and intravenous fluids until 17.00 hours on that day. This final illness was caused by a Salmonella meningitis. This was his second episode of Salmonella meningitis, with both episodes caused by a very rare subspecies of Salmonella, that of Salmonella Brandenberg. The source of the Salmonella infection was not established, despite a full UKHSA investigation, nor was it clear whether the second episode was a reinfection or a relapse following the first Salmonella infection. Tommy had also had an episode of Group B streptococcal meningitis in the early neonatal period.

	The repeated serious infections, including with an unusual organism, suggested the possibility of an immune deficiency, but no specific condition was established. Whilst the first two episodes of meningitis were treated appropriately, there were a number of missed opportunities to render care to Tommy on 7.12.22, specifically the delay in triage, the incorrect calculation of the Paediatric Observation Priority Score (POPS), and the lack of recognition of how unwell he was on admission. This led to the lack of escalation to a senior doctor, the lack of completion of a Paediatric Early Warning Score (PEWS), the lack of repeat urgent observations (which should have been every 30 minutes reviewing response to urgent fluid boluses) from admission. IV antibiotics should have commenced within 30 to 60 minutes of his presentation to hospital. Sepsis was clearly present by 1328 on that day, and very likely present at 12:35 although this was not recognised. The sepsis 6 chart, if it had been completed correctly by the paediatric team who have far more experience of assessing young babies, would have identified sepsis and led to immediate treatment with fluids and antibiotics. Additionally there was a further opportunity to render care at 1510 when the repeat observations remained high with the PEWS of nine- again there was no nursing or medical response to Tommy clinical picture of sepsis, at this point Whilst these issues of care at KMH on 7.12.22 are very serious, it is not possible to say that they caused, or made a more than minimal contribution to Tommy's death, as he had such a serious and overwhelming infection, and was likely to be unable to mount an effective immune response as he was so young, and had already had two serious infections Detailed Findings as to how he came by her death are provided in a written Determination dated 15.3.24, 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. At times of high pressure and business, the Paediatric nursing complement is insufficient in the Emergency Department. There are inexperienced Paediatric nurses trying to manage a very high workload, without senior nurse support to try and increase staffing levels on a shift. The Facing the Future (RCPCH) standards for levels of Paediatric nursing are not met 2. Handovers and key conversations between staff, both nursing and medical staff, in ED and with Paediatric staff are not routinely documented, and outcomes from handovers and escalations do not result in clear action plans and allocated tasks

	3. The system for recognising an ill baby in Paediatric ED is not robust- from the point of attendance, through timely triage, timely escalation, and joint assessment by senior 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 **30th 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. Tommy'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	 **4th April 2024** **Dr E A Didcock** **H M Assistant Coroner for Nottingham and Nottinghamshire**