REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** Mid and South Essex NHS Partnership Trust
1	**CORONER** I am STEPHEN SIMBLET KC assistant coroner, for the coroner area of Essex.
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 11th April 2023, I commenced an investigation into the death of Selina Samarina, aged 2. The investigation concluded at the end of the inquest on 28th May 2024. The conclusion of the inquest was that the deceased died of natural causes, the medical cause of death being that she had died from sepsis and pneumonia, with contributory factors of Down's Syndrome and Upper Respiratory Tract infection. She died in Broomfield Hospital
4	**CIRCUMSTANCES OF THE DEATH** Selina had been brought into hospital by her parents with symptoms of fever, a rash and irritability. She was made an urgent referral and the sepsis protocol/ procedure was triggered. That should ordinarily lead to an examination by a senior doctor within an hour. In this case, a very junior doctor was sent over, in part because there was huge demand on the ward services and the available doctors of seniority were otherwise engaged with other patients. Selina's diagnosis was thus arrived at by a relatively junior doctor, and other possible diagnoses such as sepsis or pneumonia were not addressed.There was no differential diagnosis. It was not until two and a half hours later that a doctor of appropriate seniority was available to assess Selina, by which time, as was consistent with the directions from the junior doctor, Selina had gone home with her parents. Evidence was given by the consultant that on that particular day, a Bank Holiday (Good Friday), there would normally be 12 doctors across the Emergency Department and Paediatrics Department, but on that day, there were only 7. This increased workload and the demand for services (which was at a normal level) had played a part in the consultant not being available to review Selina's condition within the timescale mandated by the sepsis protocol,
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 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) I was told in evidence that the Trust has now consolidated the staffing rotas for the Emergency Department and Paediatrics Department, so that it is now easier to see any deficit as one deficit across two departments. That does not however, address the situation of how and why a situation in which only 60% of the doctors are available for these important services. (2) I am concerned about the overall sufficiency of the staffing arrangements.
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 31 July 2024. 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 parents: ([redacted]); nurse in charge [redacted] Since the deceased was under 18, it may also be necessary to inform the LOCAL SAFEGUARDING BOARD (where the deceased was under 18)]. I have also sent it to Health Service England 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	**19th June 2024**