Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Secretary of State for Department of Health & Social Care**
1	**CORONER** I am Nigel PARSLEY, HM Senior Coroner for the coroner area of Suffolk
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 20 December 2023 I commenced an investigation into the death of Regan Edwin James SMITH aged 11. The investigation concluded at the end of the inquest on 23 July 2024. The conclusion of the inquest was that: Narrative Conclusion - Regan's death was the result of an untreated natural cause, following a missed opportunity to provide medication which would have prevented his death from occurring. The medical cause of death was confirmed as: 1a Multiorgan Failure 1b Acute Liver Failure 1c Diabetic Ketoacidosis
4	**CIRCUMSTANCES OF THE DEATH** Regan Smith was declared deceased at the Kings College Hospital, Camberwell, in London on the 31st January 2023. On the 23rd January 2023 Regan had begun to breathe in a strange manner, so following a call to NHS 111 he was taken to the Accident and Emergency Department of the Ipswich Hospital. Once there Regan's father spoke to a doctor who said he would only be checking for laryngitis, so his father took him home with a view to seeing a GP the next day. On the 24th January 2023 Regan was seen at his GP Surgery and laryngitis was diagnosed. On the 25th January 2023 Regan's breathing changed rapidly, so an ambulance was called. A finger prick test was conducted by the ambulance crew showing Regan's blood glucose level was much higher than it should have been. Regan was taken to the Accident and Emergency Department of the Ipswich Hospital, but the patient handover between the ambulance personnel and Accident and Emergency personnel was conducted in such a manner as to be ineffective. As a result, the earlier blood glucose test was not recorded on the Accident and Emergency records, and therefore not taken into consideration by treating clinicians at the Ipswich Hospital.

	Due to Regan's blood glucose level, he should have had further tests conducted, and it is more likely than not that he would have been immediately admitted, with treatment started to reduce his blood sugar level. However, in the absence of the initial blood glucose level result, no further glucose blood testing was undertaken, and Regan was discharged home with his father later that evening. On the 26th January 2023 Regan collapsed at home, and was taken initially to the Ipswich Hospital, but was transferred to Addenbrookes Hospital due to the seriousness of his condition. Regan had severe metabolic acidosis caused by previously undiagnosed diabetes. Once in the Paediatric Intensive Care Unit at Addenbrookes it was identified that Regan's liver was beginning to fail, so he was transferred to a specialist unit at the Kings College Hospital in London. Once at the Kings College Hospital Regan's condition continued to deteriorate until his sad death on the 31st January 2023
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) The information to save Regan's life (his abnormal blood glucose reading) was in the possession of the NHS at a time when lifesaving treatment could have been given to him on the 25th January 2023. Regan's death occurred as the result of an identifiable single point of failure (the ineffective handover process), as this led to a significant and known clinical finding being unavailable to his treating clinicians. Evidence heard that the handover system in Regan's case was reliant on both ambulance and Accident and Emergency personnel making and receiving a verbal handover. The IT systems used by the Ambulance and Hospital Trusts are not directly compatible, and therefore clinical information (such as blood glucose level test results) are not immediately available to hospital personnel in every case. It was heard that Regan's verbal only handover occurred during a period of very high acuity. On the 25th January 2023 the unit was exceptionally busy, the staff there had a high number of other sick children to care for, there was no cubicle space available, and the staff had not been able to take any of their scheduled breaks. When Regan did see a clinician, it was in the corridor. It was heard in evidence that there was no national protocol, no national standard operating procedures, and no National Institute for Health and Care Excellence guidance, in relation to the conduct of patient handovers at Accident and Emergency Units. In addition, there is no national protocol, no national standard operating procedures, and no National Institute for Health and Care Excellence guidance, to ensure basic observations are confirmed as being handed over by ambulance personnel, and confirmed as being

	received by the receiving Accident and Emergency personnel.
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 September 18, 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 [redacted] **Chief Executive Officer East of England Ambulance Service NHS Trust** **Chief Executive Officer East Suffolk & North Essex NHS Trust** **Chief Executive Officer Cambridge University Hospital (Addenbrookes) NHS Trust** **Chief Executive Officer Kings College Hospital NHS Trust** 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	**Dated: 24/07/2024** **Nigel PARSLEY** **HM Senior Coroner for** **Suffolk**