REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], President Royal, Royal College of General Practitioners, 30 Euston Square, London, NW1 2FB** **2. [redacted], President of the Royal College of Paediatricians and Child Health, 5-11 Theobalds Road, London, WC1H 8SH** **3. [redacted], President of the Royal College of Surgeons, 35-43 Lincoln's Inn Fields, London WC2A 3PE** **4. [redacted], President of the Royal College of Radiologists, 63 Lincoln's Inn Fields, London WC2A 3JW**
1	**CORONER** I am Dr Julian Morris, senior coroner, for the coroner area of London Inner South
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 18.6.2021 I commenced an investigation into the death of Lacey May Brookman, aged 11. The investigation concluded at the end of the inquest on 11.10.2024. The conclusion of the inquest was a narrative conclusion.
4	**CIRCUMSTANCES OF THE DEATH** That narrative conclusion summarises the events as follows: Lacey was 11 when she had suffered over a week of varying abdominal pains associated with nausea, vomiting, constipation and low-grade fever. After approx. 10 days her mother had a telephone consultation with her GP. Some of her symptoms appeared to be settling and it was determined she had been/was suffering from a viral illness. She was given safety netting advice. Three days later she re-presented to another GP at the same practice who considered she had appendicitis; she was transferred to hospital. There she was seen by A&E and surgical doctors. The registrar did not consider she had appendicitis but perhaps another diagnosis and arranged for her to be reviewed on the ward later the same day. She went home in the interim at about 0200 (24/4//2021). The consultant reviewed her later that day and considered she was unwell but could not reach a diagnosis. He arranged for an urgent abdominal ultrasound, +/- CT scan. Those investigations revealed a retrocaecal, perforated appendix with abscess formation and right sided hydronephrosis. The evidence was that the appendix had likely perforated before the original GP telephone review (20/4/2021). Lacey was transferred to a specialist paediatric unit for operation the following day (25/4/2021) but developed a duodenal ulcer and coagulopathy as a result of her condition. The appendix was removed but Lacey had an extremely stormy post-operative period. That post operative period included further operations, leaving her abdomen open, on-going coagulopathy, disseminated intravascular coagulation and ultimately widespread multiorgan failure. Despite the input of 2 further hospitals, she did not survive and died on 4/6/2021 at 17.25hrs The Inquest also heard expert evidence from a Consultant Paediatric Surgeon who explained that

	(1) Acute Retrocaecal appendicitis occurs in about one-third of acute appendicitis presentations (2) that it is difficult to determine as its presentation is not 'classical' in terms of right sided abdominal pain and presenting symptoms (3) it therefore often presents late and following perforation and with complications already present, and (4) the availability of abdominal ultrasound +/- CT scan is therefore critical in diagnosing its presentation. The court also heard about the Surgical Abdominal Pathway and 'Getting It Right First Time' (re appendicitis) and the NICE guidelines (about which there is a brief reference to retrocaecal appendicitis). However, from the evidence I heard in court, I do not consider there is sufficient knowledge and awareness and therefore consideration from junior staff in relation to this particular type of presentation of acute appendicitis. In addition, the importance of carrying out an abdominal ultrasound (+/- CT) was highlighted. The evidence was that this could only be provided by the on-call radiologist, which therefore restricted its availability and assistance in making the diagnosis.
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. Neither the original GP, the reviewing surgical SHO or surgical registrar considered that Lacey had appendicitis. The Consultant surgeon reviewing Lacey on the 24th, considered she was ill but could not reach a diagnosis. 2. Despite the slant of available literature, it was evident retrocaecal appendicitis presentation is not a rare presentation of either acute appendicitis or generalised abdominal pain (both common presenting features in the young) 3. The availability and use of bedside/ departmental ultrasound scanning in abdominal pain (e.g. in the young) at any time, but especially out of hours 4. The training of doctors in considering the diagnosis as a possible differential to generalised abdominal pain.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you your organisations 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 Thursday 12th December 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] James Paget Hospital

	King's College Hospital Addenbrooks [and to the to all safeguarding boards in Norfolk, Cambridge and covering Kings (where the deceased was under 18)]. 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	**[DATE]** 8th November 2024	**[SIGNED BY CORONER]** Dr Julian Morris