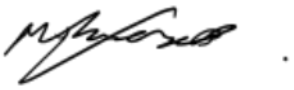
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 ASHTON MEDICAL PRACTICE** **2 SSP HEALTH** **3 WIGAN INTERGRATED CARE BOARD**
1	**CORONER** I am Michael James Pemberton, HM Assistant Coroner for the coroner area of Manchester (West).
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 17 January 2023 I commenced an investigation into the death of Hailey Anne Thompson aged 22 months. The investigation concluded at the end of the inquest held with a jury on 3 April 2025. The conclusion of the inquest was natural causes, and the medical cause of death was 1a Sepsis, Pneumonia (Group a Streptococcus)
4	**CIRCUMSTANCES OF THE DEATH** Hailey Anne Thompson attended her GP on 7th December 2022 and was prescribed antibiotics to treat bacterial tonsillitis. They were subsequently stopped after 3 days due to Hailey developing a rash, thought to be an allergic reaction. There was a missed opportunity for this to be reviewed at primary care level, however this did not contribute to her death. Hailey remained unwell and was seen by her GP on 16th December 2022, and again on 18th December 2022 at the A&E department at the Royal Albert Edward Infirmary in Wigan. On both occasions a viral upper respiratory infection was diagnosed and therefore, antibiotics were not required. On the morning of 19th December 2022, Hailey was found unresponsive at home. She was transported to the Royal Albert Edward Infirmary in Wigan by ambulance. Efforts to resuscitate her were unsuccessful and she was declared deceased. The cause of death was sepsis, arising from Streptococcus A infection in the lungs causing Pneumonia.
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: 1. During the course of evidence, an issue was explored regarding Hailey's mother attempting to obtain an appointment or advice with the GP surgery following an apparent allergic reaction to prescribed antibiotics. These had been prescribed on 7 December for tonsilitis but stopped after three days due to an apparent allergic reaction.

	2. During a call to the GP surgery, Hailey's mother spoke with an administrative member of staff (who at the inquest was referred to as a care navigator at a call centre). The staff member referred an appointment to a pharmacist working with the practice to call her. 3. The pharmacist to whom this was assigned was not competent to deal with a paediatric medication enquiry and sent a message back advising of this, albeit not on the medical records system where an auditable trail would exist. On the evidence, the pharmacist was not provided with feedback directly on the need to use the medical records system or involved in the lessons learned process as they were not directly employed by the practice. 4. A further concern arose during the course of evidence from the primary care practice manager that a care navigator may not have a clear pathway on whom to refer a task or action to, or triage tool to recognise that a reported allergic reaction to a medication may require urgent consideration by a doctor to assess any risk of anaphylactic shock. 5. No evidence was provided to: a. explain how a patient telephoning the practice and being answered by the call centre would be referred to the urgent triage doctor on duty at the practice, b. whether a list of clinician competencies and whom to refer tasks to was held c. Care Navigator training d. Algorithms or policies that apply to assist care navigator / call handlers at a centre which is not located within the doctor surgery. 6. These issues are important as I had no reassurance that an administrative member of staff who spoke with a patient contacting the practice, had a clear pathway or guidance on whom the required task should be referred to. 7. Instead, the task could be allocated using judgement (although as above, guidance to apply this was not clear) to a clinician who could not in fact assist, which occurred in this case. The jury who heard the inquest found that there was a missed opportunity to review the antibiotics, which was not causative in this case. In my opinion, there is a risk that an urgent need for appropriate clinical referral may not occur in the above circumstances.
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 30 May 2025. 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] **– Parents** **Wrightington Wigan and Leigh Teaching Hospitals NHS Trust** [redacted]

	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	**Dated: 4 April 2025**  **Michael James Pemberton** **HM Assistant Coroner for** **Manchester West**