The Inquest Touching the Death of Rose Annie Harfleet
A Regulation 28 Report – Action to Prevent Future Deaths

THIS REPORT IS BEING SENT TO:

- **Chief executive, NHS England**
- **National Medical Director, NHS England**
- **Chief Medical Officer, England**
- **Health Secretary, Department of Health**
- **Chief Executive, CQC**
- **President – Royal College of Paediatrics**
- **President - Royal College of Emergency Medicine**
- **Chief Executive, Royal Surrey County Hospital, NHS Foundation Trust**

CORONER
Dr Karen Henderson, HM Assistant Coroner for Surrey

CORONER'S LEGAL POWERS
I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.

INVESTIGATION and INQUEST

On 10th June 2024 I resumed the inquest into the death of Rose Annie HARFLEET. On 3rd March 2025 I concluded the Inquest. At the time of her death Rose was 12 years of age.

The medical cause of death given was:

1a Colonic Gangrene and Aspiration Pneumonia

1b. Caecal Volvulus

2. Mosaic Trisomy 17

I found:

On the 29th January 2024 Rose Annie Harfleet accompanied by her mother attended the Emergency Department of the Royal Surrey County Hospital, Guildford, after Rose had a sudden onset of abdominal pain and vomiting earlier that morning on a background of

chronic intermittent constipation. From birth Rose was diagnosed with mosaic trisomy 17(with global developmental delay.

During her admission Rose vomited green bile indicative of intestinal obstruction which was confirmed on an abdominal x-ray undertaken at 18.32 and informally reported at or around 19.45 hours that evening. A plan was made to contact the surgical team at St George's Hospital as the tertiary referral centre and to transfer Rose for further assessment and management. This was not facilitated.

Instead, Rose was transferred to the children's ward at the hospital on or around midnight and treated for constipation in the absence of a surgical review and without appropriate observations or monitoring and a lack of understanding that this was a time critical intestinal obstruction with bilious vomiting.

There was a failure of the medical and nursing staff to appreciate Rose was clinically deteriorating. Rose had a cardiorespiratory arrest at 06.15 hours. Resuscitation was unsuccessful and Rose was recognised to have died at the hospital at 07.48 hours on 30th January 2024.

An autopsy confirmed the abdominal pain, and clinical deterioration was due to a caecal volvulus causing intestinal obstruction and bowel ischaemia.

If the transfer had been facilitated as initially planned curative surgery would have been undertaken and Rose's death would have been prevented.

CIRCUMSTANCES OF THE DEATH

Please see my findings above

CORONER'S CONCERNS

1. The management of children with profound disabilities within a hospital setting

Rose was a deeply loved child who brought great joy to her mother, wider family and all that knew her. During the inquest hearing no national or local guidance was forthcoming to assist medical and nursing staff, within a conventional hospital setting, to appropriately manage patients such as Rose who had a global developmental delay and was wholly reliant on her mother to advocate on her behalf. This gives rise to a concern that this omission adversely impacts the care that patients such as Rose receive.

2. Guidelines - consultation with parents and guardians of children with profound disabilities within a hospital setting

Rose's mother was devoted to Rose and was very able to advocate on Rose's behalf as well as being best placed to provide the vital information about her signs and symptoms given Rose was unable to do this for herself. The importance of obtaining this information was not understood by the paediatric consultant who took no history from Rose's mother

and underestimated the severity of her signs and symptoms. The consequence of this was that Rose's voice – through her mother as her advocate – was not heard and she was not therefore able to actively participate in the care and management that was provided to Rose, the corollary of which resulted in poor clinical decisions which contributed to Rose's death. This gives rise to a concern that by not listening to parents or guardians as a matter of course leads to discrimination of disabled children.

3. Nursing and Medical care on the ward

In the absence of local and national guidelines, the importance of listening and responding to Rose's mothers ongoing concerns about her daughter when she was transferred to the ward were not recognised by the nursing and medical staff and consequently not acted upon thereby contributing to Rose's death. There appears to be a prevailing culture that in the absence of a patient being able to explain their symptoms themselves the voice of the parent or guardian is not given the significance it should be for the most vulnerable in a hospital setting.

4. LeDeR Role

Rose's admission was during the working week, yet there was no consideration or offer given to Rose or her mother during her time in the Emergency Department to being introduced to a learning Disability Liaison Nurse. This led to Rose's mother being unsupported during this admission or for a nursing professional to be able to liaise and advocate for Rose and her mother with medical and nursing staff in the emergency department. This again gives rise to a concern that patients such as Rose and her mother are adversely impacted on the care that they receive in the absence of local and national guidelines that this should be routinely available and offered as a matter of course.

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of its date; I may extend that period on request.

Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise, you must explain why no action is proposed.

COPIES

I have sent a copy of this report to the following:

1. [redacted] – Mother
2. [redacted] – Grandfather
3. [redacted] – Medical Director – RSCH, Guildford

In addition to this report, I am 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 at the time of your response, about the release or the publication of your response by the Chief Coroner.

Signed:

Karen Henderson

DATED this 13th Day of May 2025