REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1) The Chief Executive, Tameside and Glossop Integrated Care NHS Foundation Trust

2) The Secretary of State for Health and Social Care

CORONER

I am Chris Morris, Area Coroner for Greater Manchester South.

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.
http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7
http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST

On 30th October 2024, Alison Mutch OBE, Senior Coroner for Greater Manchester (South) opened an inquest into the death of Lila Airelle Marsland who died at home on 28th December 2023, aged 5 years. The investigation concluded with an inquest which was heard between 27th May to 5th June 2025 before a jury.

A post mortem examination determined Lila died as a consequence of Pneumococcal Meningitis (Streptococcus Pneumoniae).

At the end of the inquest, the jury returned the following Narrative Conclusion:

> '*Lila Airelle Marsland died as a consequence of undiagnosed and therefore untreated Pneumococcal Meningitis (Streptococcus Pneumoniae) a number of hours following her discharge from hospital. Lila's death was contributed to by neglect.'*

CIRCUMSTANCES OF THE DEATH

Lila Marsland was brought to Tameside General Hospital on 27th December 2023, having become unwell that day with symptoms of headache, fever, lethargy and neck pain. Following interaction over the hours which followed with a range of healthcare professionals, Lila was discharged home with a diagnosis of viral tonsillitis and a prescription of oral antibiotics and a throat spray. Lila was found to have died around six and a half hours after her discharge from hospital.

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 will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows. –

<u>To the Chief Executive, Tameside and Glossop Integrated Care NHS Foundation Trust</u>

1. Having carefully considered the oral evidence given in court by a range of different clinicians with varying roles and remits, I am concerned that, notwithstanding the work the Trust has undertaken in response to Lila's death, the Child Sepsis Screening Tool is not yet fully embedded in the minds of those who assess and treat Children and Young People at the Trust;

2. I am concerned that the Trust is yet to fully implement the latest iteration of the National Institute of Health and Care Excellence's Guideline *Meningitis (bacterial) and meningococcal disease: recognition, diagnosis and management* (NG240 Published 19 March 2024);

3. It is a matter of concern that the Locum Consultant in Emergency Medicine who completed a form indicating Lila was 'Safe to Transfer' to the Paediatric Emergency Department did so without undertaking any examination or direct assessment of her. The doctor had previously filed a statement at court indicating he had undertaken a '*preliminary visual assessment*' of Lila, but accepted in oral evidence that this was not, in fact, the case;

4. I am concerned that no medical record appears to exist of the examination of Lila which was undertaken by the Locum Registrar in Paediatrics which resulted was discharged from hospital. The absence of this key piece of evidence serves to limit the ability of the Trust to derive all possible learning from Lila's death.

<u>To the Secretary of State for Health and Social Care</u>

The court heard evidence that, over the course of almost 10 hours in hospital, Lila's history and details of examinations and assessments undertaken were recorded on a mixture of various analogue and digital systems in operation in different parts of the Trust, leading to a risk of vital clinical information being lost in the system.

I am concerned that this, and other hospitals elsewhere in the country, continue to operate with information being stored and shared between professionals in a fragmented and disjointed way.

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by **6th August 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner, together with the family and the Trust's legal representatives.

I have also sent a copy to the Care Quality Commission and the General Medical Council, 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.

Dated: **11th June 2025**

Signature: **Chris Morris, Area Coroner, Manchester South**.