OSCAR MICHAEL THOMAS KEENAN

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. South Central Ambulance service. Quality Improvement.** **2. NHSE/ NHS digital**
1	**CORONER** I am Judith Leach, assistant coroner for the coroner area of Oxfordshire
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 3 May 2025, I concluded an inquest into the death of Oscar Keenan, age 30 days. I made a narrative determination, which I attach. I concluded that the medical cause of death was 1a sepsis 1b Escherichia coli bacteraemia. 1c antenatally diagnosed hydronephrosis with Rt pelvicalyceal dilatation on prenatal ultrasound 2. nil recorded I gave a brief narrative conclusion as follows: **Oscar died following sepsis caused by an underlying naturally occurring e-coli infection. At the time Oscar was not receiving antibiotic prophylaxis.**
4	**CIRCUMSTANCES OF THE DEATH** Oscar was born on 27 May 2024 with a pelvi-ureteric junction obstruction (PUJO). An anomaly that was first seen on antenatal scanning. He remained well after a short course of antibiotics and was discharged home. Th inquest heard that antibiotics were to have been restarted but this did not happen. This anomaly can carry a risk of infection. On 26 June 2024 Oscar's condition deteriorated rapidly and catastrophically following a bacterial infection that was sensitive to the prescribed (but not received) antibiotics. A call was made to the 111 at 05.31 on 26 June 2024 reporting that Oscar was having breathing difficulties. The call handlers who use the algorithms are non-clinical and cannot identify a more urgent situation by asking the right questions of the caller. Also, the algorithm does not appear to assist in early identification of a serious problem in a newborn. A GP was asked to call back within the hour which occurred and after questioning the family, the GP instructed the parents to take Oscar immediately to the nearest ED (John Radcliffe). The GP then pre-alerted the hospital. Oscar was found to have sepsis and this led to his death in hospital that same day.

	A separate regulation 28 report has also been sent to the GP service.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion the 111 algorithm is not effective in assessing the deteriorating newborn particularly in the case of altered breathing and sepsis. 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] (1) The apparent inadequacies of the present algorithm in assessing ill newborns/ infants, particularly in identifying significant respiratory problems that require early clinical assessment (2) Total reliance on the algorithm which does not appear to direct early clinical input. (3) A delay/lack of direction in obtaining clinical assessment. I have concerns that this is widespread and could occur in other areas.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths, and I believe you/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 7th 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: Oscars parents The Oxford University Hospitals NHS Trust Buckinghamshire Healthcare NHS Trusts 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 other 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.

9	**[DATE] 12.06.2025**