REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Chief Executive, East Midlands Ambulance Service NHS Trust ('EMAS')**
1	**CORONER** I am Dr Elizabeth Didcock, Assistant Coroner, for the coroner area of Nottinghamshire
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 27.12.24, I commenced an investigation into the death of Zara Alice Cheesman The investigation concluded at the end of the inquest on the 17th September 2025 The conclusion of the inquest was a Narrative as follows: Zara developed meningococcal meningoencephalitis, a devastating disease, with early symptoms likely beginning late afternoon on 19.12.24. These early symptoms were non-specific, and the assessment of Zara at the Childrens Emergency Department at Queens Medical Centre on 20.12.24 was reasonable, although it is likely that the meningitis was in its early phase at this time. The assessment on 21.12.24 by the EMAS crew, following parents again seeking help and advice as they had identified that Zara was now incoherent and confused, should have led to an admission to hospital, which would have led to treatment for the meningoencephalitis, and on balance Zara would have survived had this occurred. Zara's illness continued to progress, and she became critically unwell, from the intracranial effects of the disease, such that by the morning of 22.12.24, the situation was irretrievable. The lack of recognition by the EMAS crew, of how unwell Zara was on 21.12.24, and the failure to following key EMAS guidelines, led to her non-conveyance to hospital on that day. This failure to convey her to hospital, has made a more than minimal, negligible or trivial contribution to her death. Zara's death was contributed to by neglect
4	**CIRCUMSTANCES OF THE DEATH** Zara died on 23.12.24 at Queens Medical Centre, Nottingham from meningococcal meningoencephalitis. She had been unwell from late afternoon on 19.12.24, with initially vomiting, and a fever, then developing a headache, with worsening lethargy. She was seen in the Childrens Emergency Department at QMC, on the afternoon of 20.12.24, following advice from the 111 service.

	The assessment by the two clinicians who saw her on that day was thorough, but incorrectly identified that Zara had a vomiting bug, rather than meningitis in its early phase. Zara then became confused with incontinence, and worsening lethargy over the subsequent hours, with development of a more severe headache overnight on the 20.12.24, which then seemed to settle. Family again appropriately sought advice from the 111 service around lunchtime on 21.12.24, as they were worried that she was incoherent, confused with episodes of incontinence, and continuing vomiting. The 111 service recognised that she required an urgent ambulance response, and an EMAS technician/trainee technician crew made an assessment of Zara at home. Despite family clearly setting out her symptoms and their concerns, the crew did not undertake an adequate assessment - there was neither an adequate assessment of the history of her illness, nor an adequate examination of Zara. The Technician attending did not recognise her new confusion, and did not recognise how unwell she was. The crew did not recognise that there was a requirement for discussion with a clinician, nor that she should have been conveyed to hospital for a necessary assessment and treatment. Zara continued to deteriorate, and family were understandably reassured that she had a vomiting bug, likely Norovirus, as Zara had now had two assessments that had not resulted in an admission. By the early morning of 22.12.24, Zara was critically unwell, with meningoencephalitis and brain swelling. Despite prompt attendance by EMAS and Helimed crews, and then all emergency management at the scene, in the Childrens Emergency Department and then in PICU, Zara died in hospital on 23.12.24. Accepting that meningococcal meningoencephalitis is a severe and life threatening disease that is rapidly progressive, and can be a difficult diagnosis to make in its early phase, there was an opportunity missed to provide treatment on 21.12.24, that would have likely been life saving.
5	**<u>CORONER'S CONCERNS</u>** 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: 1. There is no detailed organisational understanding of the extent of the issues identified in this case - that of the very limited assessment of a child or young person, the reliance on the incorrect physiological scoring system used, and the non- conveyance decisions made 2. There is insufficient audit and monitoring of EMAS operational staff by senior clinical staff, to ensure there is both understanding and following of key EMAS guidelines 3. There is insufficient continuing professional development for operational staff in respect of the assessment of sick children and young people, with frontline staff having limited knowledge and understanding of the Children and Young Persons clinical guideline (that includes the importance of listening to parents, physiological

	scoring systems in children, and the significance of a change in mental state of a child or young person) I am not reassured that necessary actions to address these serious issues identified are in place.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe you 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 the **20th November 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: 1. The family 2. The Nottingham University Hospitals NHS Trust 3. The Nottingham and Nottinghamshire Integrated Care Board 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	**25th September 2025 Dr E. A. Didcock**