

## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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

	<p><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO:</b></p> <ol style="list-style-type: none"><li><b>1. Chief Executive of Basildon Hospital (Mid &amp; South Essex NHS Trust)</b></li><li><b>2. The Royal College of Paediatrics and Child Health</b></li></ol>
1	<p><b>CORONER</b></p> <p>I am Jyoti Gill, assistant coroner, for the coroner area of Essex</p>
2	<p><b>CORONER'S LEGAL POWERS</b></p> <p>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.</p>
3	<p><b>INVESTIGATION and INQUEST</b></p> <p>On 4 November 2024 an investigation into the death of Viviana-Ray Winnie Elsie Wendy Butnaru, age 14 months was commenced. The investigation concluded at the end of the inquest on 4 February 2026. The conclusion of the inquest was a narrative conclusion which stated that Viviana-Ray Winnie Elsie Wendy Butnaru died of complications arising from the onset of myocarditis caused by Parvovirus contributed to by a background of bronchiolitis and bronchopneumonia.</p>
4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>Police referral.</p> <p>Viviana-Ray Winnie Elsie Wendy Butnaru attended the Children's Emergency Department (Basildon Hospital) at 23:18 on 24 October 2024. Chest X rays were taken which identified cardiomegaly, but these were not officially reported until 29 October 2024 (after Viviana-Ray had passed away). Initially an Emergency Department Registrar had suspected that the chest X ray showed an enlarged heart. This information was not recorded anywhere but verbally handed over by the ED Registrar to the Paediatric Registrar. The Paediatric Registrar in evidence did not recall this verbal handover. The Paediatric Registrar had not identified an enlarged heart upon her review of the chest X ray. Blood gases were taken which showed Viviana-Ray to be in metabolic acidosis, but these were not reviewed by the Paediatric Registrar when the results were initially made available during her shift.</p> <p>The Associate Director of Nursing for Paediatrics at Mid &amp; South Essex NHS Trust stated that the Children's Early Warning Tool ("CEWT") Red score was not escalated in accordance with trust policy. No blood pressure readings were ever taken of Viviana-Ray, and it was stated that all children presenting to the Paediatric Emergency Department should be reviewed using the PIER Sepsis Tool during triage which was not completed for Viviana-Ray. The Trust also stated that when Viviana-Ray had an Amber score with two triggers which requires a review by the Nurse in Charge (NIC) and a Paediatric Registrar within 20 minutes, that this was also not complied with.</p> <p>Aside from the initial observation, no other observations or nursing documentation was completed during Viviana-Ray's attendance at the Paediatric Emergency Department.</p> <p>Whilst a review took place at 10:15 am on 25 October 2024 by the Paediatric Consultant, no further review appears to have taken place until 16:00 later that day. The Paediatric Consultant stated that clinically Viviana-Ray looked like she was improving</p>

	<p>despite Viviana-Ray's blood gas levels showing she was in metabolic acidosis. A repeat blood gas was not performed as the Paediatric Consultant attributed any decline in these results to be associated with her bronchiolitis and suspected sepsis and no other underlying cause for the metabolic acidosis was explored.</p> <p>The Paediatric Consultant had not noticed an enlarged heart on Viviana-Ray's chest X ray and stated that it was normal for children to often have slightly larger hearts on X rays due to the angles in which these are taken. The Paediatric Consultant stated that staff had not made her aware of any further concerns during the remainder of her shift except until 4 pm when a nurse notified her that Viviana-Ray was working harder with her breathing.</p> <p>During the inquest another Paediatric Consultant giving expert evidence (and involved in the Patient Safety Incident Report) stated that she found that there were features of mild to possibly moderate cardiomegaly (enlarged heart) on both chest X-rays. The Paediatric Consultant stated that it would be difficult to definitively determine whether the missed identification of cardiomegaly would have led to a cardiac arrest, but that earlier detection and intervention, including additional investigations and consultation with a tertiary Paediatric Cardiology centre, might have provided further insights and possibly informed management decisions.</p> <p>The Associate Director of Nursing for Paediatrics stated that based on Viviana-Ray's physiological parameters and CEWT score, earlier medical reviews would have been beneficial considering her clinical trajectory.</p> <p>Viviana-Ray's breathing was worsening, and her condition began to deteriorate around 9 pm on 25 October 2024 and it was at this time when it was first suspected that Viviana-Ray was experiencing heart failure.</p> <p>Arrangements were made for urgent intubation. A crash call was put out for the anaesthetic team. Viviana-Ray had lost her pulse, and pulseless electrical activity was confirmed at 21:46. Viviana-Ray was intubated and Cardiopulmonary Resuscitation continued following the Non-shockable Pathway. Viviana-Ray had CPR for 51 minutes but was sadly declared deceased at 22:37 at Basildon Hospital. The cause of death is myocarditis caused by the Parvovirus, contributed to by a background of bronchiolitis and bronchopneumonia.</p> <p>Expert evidence in this case noted that by the time the heart failure was clinically obvious there would not have been an opportunity to reverse the situation as Viviana-Ray arrested shortly afterwards. The expert went on to say that Parvovirus was the likely cause of the myocarditis and that Acute Fulminant Myocarditis is characterised by the rapid onset of severe heart failure and cardiogenic shock, requiring advanced pharmacological or mechanical circulatory support. The expert also stated that there has been a recent surge in Parvovirus amongst children following the Covid pandemic. It was stated that diagnosing this remains challenging and that it would be helpful for paediatricians to have guidance on how to identify such cases.</p>
5	<p><b><u>CORONER'S CONCERNS</u></b></p> <p>During the course of the inquest the evidence 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.</p> <p>The <b>MATTERS OF CONCERN</b> are as follows. –</p> <p>National Concerns:</p> <p>(1) There appears to be a lack of local or national guidelines assisting those assessing patients in an accident and emergency and paediatric environment to assess the correct pathway for identifying and investigating those who may present with heart related issues such as myocarditis.</p>

	<p>(2) Raising awareness of the existence of Parvovirus considering the surge of this virus in children post the Covid 19 pandemic.</p> <p>Local Concerns:</p> <p>(3) Chest X rays which showed cardiomegaly were not reported officially by a radiologist until several days later.</p> <p>(4) Underlying causes for metabolic acidosis were not fully explored. Greater awareness of the difference between metabolic and respiratory acidosis is required.</p> <p>(5) Incomplete documentation to be addressed to include all updates from nursing staff in relation to observations and escalations; and handovers from the medical team to one another to be clearly recorded.</p>
6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>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.</p>
7	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 29<sup>th</sup> April 2026. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons</p> <p><b>[REDACTED] (Miss Viviana-Ray Butnaru's Mother)</b>  <b>The Care Quality Commission</b>  <b>NHS England</b>  <b>[REDACTED] (Expert Witness)</b></p> <p>I have also sent it to <b>[REDACTED] of Gadsby Wicks (Family Solicitor)</b> who may find it useful or of interest.</p> <p>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.</p> <p>I may also send a copy of your response to any other person who I believe may find it useful or of interest.</p> <p>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.</p> <p>You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response.</p>
9	<p><b>DATED: 4<sup>th</sup> March 2026</b></p> <p><b>[REDACTED]</b>  <b>Assistant Coroner for Essex</b></p>