The Inquest Touching the Death of Oliver Charles Major Shelley
A Regulation 28 Report – Action to Prevent Future Deaths

THIS REPORT IS BEING SENT TO:

- **NHS England**
- **NHS Pathways**

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 16th February 2026 a jury inquest was resumed into the death of Oliver Charles Major Shelley. On 17th February 2026 the inquest was concluded. At the time of his death Oliver was 17 years of age.

The medical cause of death given was:

1a. Multi-Organ Failure

1b. Meningococcal Septicaemia

The jury found:

Oliver was generally fit and well with no underlying medical problems. Oliver became noticeably unwell in the early afternoon of the 22nd July 2024. Oliver's parents phoned emergency services at 14.51 hours on the 22nd July 2024. The parents reported Oliver as showing symptoms of meningitis including a non-blanching rash at the time of the 999 call. In the absence of an ambulance being dispatched, the parents took the decision to take Oliver to East Surrey Hospital, arriving at or around 15.55. On admission, Oliver was recognised to be unwell, with a widespread rash and evidence of septic shock and organ dysfunction from a presumptive diagnosis of Meningococcal Septicaemia. Oliver was treated for Meningococcal Septicaemia according to the sepsis protocol, which included IV antibiotics, IV fluids and other medications, shortly after admission. Oliver briefly showed signs of responding to treatment. Following maximal available supportive treatment, including intubation and ventilation Oliver continued to clinically

deteriorate. Oliver was recognised to have died at East Surrey Hospital, Redhill at 23.30 hours on the 22nd July 2024 around 7.5 hours after admission.

Narrative conclusion:

Died as a result of complications of overwhelming meningococcal septicaemia

CIRCUMSTANCES OF THE DEATH

Please see the findings of the jury above

CORONER'S CONCERNS

1. The lack of a sepsis algorithm pathway to assist the emergency medical advisor (EMA) during 111/999 calls

At 14:51 hours on 22nd July 2024, Oliver's parents called 999 indicating their concern that Oliver was suffering from meningitis as he was suffering from a non-blanching rash, vomiting and reduced level of consciousness. The EMA began a triage using NHS Pathways algorithm but as they were unable to prioritise any of the listed symptoms, they requested operational support at 14:57 hours, to ask if there was a meningitis pathway within the system. This call was concluded at 15:51 with the EMA indicating to Oliver's parents that a call back was scheduled within 20 minutes.

A call back was not undertaken until 1 hr and 41minutes later and in the absence of a response a further unsuccessful call was made 2 hrs and 18 minutes later before Secamb closed the referral. In the meantime, Oliver's parents made the decision to convey Oliver to hospital arriving there at or around 15:55 hours. On attendance it was recognised that Oliver was gravely unwell and despite maximal supportive management sadly died from overwhelming meningococcal septicaemia 7.5 hours after his arrival.

In their investigation, Secamb acknowledged that the EMA's management of the 999 call was not compliant and have taken the opportunity to offer ongoing training. However, it was also recognised EMA's found it challenging to triage individuals when multiple signs and symptoms were present in relation to a possible sepsis diagnosis and that having a dedicated sepsis algorithm would assist them in being able to provide an appropriate response to callers and to ensure appropriate management. This has important implications for prioritising ambulance disposition, which may also include the ability of a paramedic to attend at the earliest opportunity to give antibiotics.

2. Emergency Medical Advisors

Other than some in-house training, Emergency Medical Advisors (EMA's), generally have no qualifications in medicine or nursing. As such, the use of this title to describe their role raises a real concern they are misleading the public who use the 111/999 service. Oliver's parents gave an extreme clear assessment of Oliver's condition and also informed the EMA that they were concerned it was meningitis. However, this was not recognised by

the EMA reaffirming their limited abilities. This reinforces the need to provide further assistance to all EMA's who use NHS pathways by providing an appropriate 'sepsis' algorithm to assist in their role.

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]
2. SECAMB
3. CDOP

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 11th Day of May 2026