The Inquest Touching the Death of Jaxon Vasco Oliveira
A Regulation 28 Report – Action to Prevent Future Deaths

THIS REPORT IS BEING SENT TO:

- **Medical Director, NHS England**
- **Health Secretary, Department of Health**
- **Chief Executive, St Peters Hospital, Chertsey**
- **Medical Director, North West Surrey Integrated Care Service (NICS)**

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 23rd April 2026 I resumed the inquest into the death of Jaxon Vasco Oliveira. On 26th April I concluded the Inquest. At the time of her death Jaxon was 3 years of age.

The medical cause of death given was:

1a. Intracranial haemorrhage
1b. Leucocytosis
1c. Acute Myeloid Leukaemia

I found:

Jaxon Vasco Olivera died on the 27th March 2025 at St Georges Hospital, London, from complications of leucocytosis secondary to Acute Myeloid Leukaemia first diagnosed on the 24th March 2025 at St Peters Hospital, Chertsey. Whilst this is a natural cause of death, the lack of recognition and finding of hepatomegaly following nursing and medical consultations, which included abdominal examinations on the 20, 22nd and 23rd March 2025 led to a delay in the diagnosis of the Leukaemia and thereafter a delay in commencing supportive measures and immediate chemotherapy to reduce the significantly elevated white cell count. Acute Myeloid Leukaemia in a child has a bleak prognosis and whilst it is therefore not possible on the balance of probabilities to conclude that earlier recognition of the hepatomegaly and subsequent management

would ultimately have prevented Jaxon's death, the delay nevertheless, did materially contribute to Jaxon dying earlier than he would otherwise have done.

CIRCUMSTANCES OF THE DEATH

Please see my findings above

CORONER'S CONCERNS

1. North West Surrey Integrated Care Service (NICS), the Acute Illness clinic and deployment of allied medical staff to assess undifferentiated paediatric patients

On the 20th March 2025, Jaxon's parents, contacted their General Practice by email for an appointment as Jaxon had been unwell with a fever and vomiting for several days. They were triaged and referred to the Acute Illness Clinic run by North-West Integrated Care Services (NWICS) where Jaxon was reviewed by an advanced nurse practitioner (ANP). The ANP was allowed to independently assess paediatric patients if over two years of age but had no paediatric nursing qualifications, nor any hospital based paediatric nursing experience. They were unable to demonstrate how to properly examine an abdomen to a standard taught to medically qualified clinicians and was erroneously documented as normal despite obvious hepatomegaly.

No evidence was provided by NWICS that the ANP or any other allied medical professional employed by them had any training or ongoing assessment to ensure competency in assessing paediatric patients including being able to undertake an abdominal examination.

Evidence was heard that it was through the recommendation of NHS England that ANP's and other allied medical staff can undertake clinical assessments of undifferentiated patient in lieu of medically qualified practitioners but there was no local or national guidance provided to be able to assess and confirm their competency to act independently without medical supervision.

This gives rise to a concern that allied medical professionals are not sufficiently able or experienced or appropriately assessed to independently review and assess undifferentiated paediatric patients.

2. Abdominal examination by a general practitioner

On the 22nd March 2025 Jaxon remained unwell. His parents took him to St Peter's hospital, where he was triaged to be reviewed by a GP at the Urgent Treatment Centre, a unit based within the grounds of St Peter's Hospital, Chertsey run by NWICS. The GP had no post-graduate qualifications in paediatrics and undertook a sub-optimal abdominal examination against expected practice whilst Jaxon was sitting on his father's lap and again failed to find hepatomegaly.

3. St Peter's Hospital Emergency Department management of Jaxon

On the 23rd March 2025, Jaxon's parents returned to St Peter's Hospital with Jaxon as he had ongoing fever, lethargy, a reduced fluid intake of 100 mls (less than 10 % of expected intake) during the day and had not passed urine. He was reviewed by an FY2 doctor undertaking a 3-month rotation in the emergency department who was allocated to work within the paediatric emergency department from time to time.

The FY2 had no previous experience in ward-based paediatrics, and no steps were in place to supervise his clinical practice allowing the FY2 to review and discharge patients independently. An abdominal examination was undertaken by the FY2, and hepatomegaly was not found despite it being present at that time. A blood test was undertaken but the FBC had clotted and was not repeated.

Jaxon was discussed with but not reviewed by the paediatric resident doctor despite sufficient evidence that a more senior review was necessary. Documentation of the consultation was very poor. Jaxon's parents were not listened to nor were their concerns acted upon. They did not know that the FY2 was not a paediatrician or that he had very limited paediatric experience leading to a lost opportunity for them to request a second opinion. The FY2 did not acknowledge nor reflect on the recent referrals Jaxon had had. This led to Jaxon being discharged by the FY2 within 90 minutes of being seen without a fluid challenge and in the absence of any evidence he had passed urine.

This gives rise to a concern as to whether it is appropriate for an FY2 to be in the position to assess and discharge undifferentiated paediatric patients without direct supervision by a more experienced clinician.

Jaxon represented to the Emergency Department at St Peter's Hospital the following morning, 12 hours or so after discharge the previous night. He was in extremis with septic shock. He had significant hepatosplenomegaly. His white cell count was profoundly elevated at nearly 500 and a diagnosis of Acute Myeloid Leukaemia (AML) causing a leucocytosis induced intracerebral haemorrhage was made. Jaxon was transferred to St George's Hospital for immediate chemotherapy. This reduced his white cell count but he sustained further cerebral haemorrhages due to leucocytosis. Further treatment was considered futile. Palliative care was provided and Jaxon died at St George's Hospital on the 27th March 2025.

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. GP – Phoenix family practice
3. President – Royal College of Paediatrics
4. President - Royal College of Emergency Medicine

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