INQUEST TOUCHING THE DEATH OF YUKI NORMAN-KNIGHT

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** The Practice Manager St Stephens Gate Medical Practice 55 Wessex Street Norwich NR2 2TJ
1	**CORONER** I am DAVID OSBORNE, Assistant Coroner, for the Coroner area of NORFOLK
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 14 MAY 2012 I commenced an investigation into the death of YUKI IVY NORMAN-KNIGHT AGED 9 MONTHS. The investigation concluded at the end of the inquest on 26 NOVEMBER 2013. The conclusion of the inquest was that Yuki died from natural causes the medical cause of death being Haemophilus Influenzae Bronchopneumonia.
4	**CIRCUMSTANCES OF THE DEATH** At the time of her death on 21 April 2012 Yuki had been suffering from a persistent cough. She was seen on three occasions in November and December 2011 and January 2012 at the Timber Hill walk in centre. She was then seen twice at St Stephens Gate Medical Practice, the GP Practice where she was registered following her birth, by practice nurses on 14 and 26 March 2012. On each occasion a diagnosis of chest infection was made and she was prescribed a 7 day course of antibiotics. She had improved for one day following the first course but then relapsed leading to her second attendance at the GP surgery. She was not seen on either occasion by a doctor, although on the second occasion the

	practice nurse gave details to a doctor when seeking his signature on the script. Sadly and tragically Yuki died on 21 April 2013 having become unresponsive whilst with her father, who commenced CPR and called 999, and taken by ambulance to Norfolk and Norwich University Hospital where despite continuing efforts she was declared deceased.
5	**CORONER'S CONCERNS** 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) Evidence given at Inquest from the Timber Hill walk in centre was that a record of a patient's attendance, if not registered at that practice, would be sent either electronically or by fax to the surgery where the patient was registered. In their evidence to the Inquest the practice nurses who saw Yuki at St Stephens Gate Medical practice could not recall if they had access to this information. I am therefore concerned that the systems for practice nurses checking an attending patient's past medical history, especially where the patient is a very young child or baby may need review. (2) On the evidence given to the Inquest there appeared to be no guidelines or triggers for when a practice nurse should refer a patient to be seen by a doctor. I am therefore concerned that the systems at St Stephens Gate Medical Practice for such a referral, especially in the case of a very young child or baby may need to be reviewed. (3) The evidence given to the Inquest was that when a caller telephoned the St Stephens Gate Medical Practice for an appointment the receptionist would ask the caller if they were happy with a nurse practitioner appointment. If the caller said they wanted a doctor then a doctor's appointment would be given. There appeared to be no guidelines for the receptionist or trigger for a doctor's appointment to be made in the absence of any specific request by the caller. I am therefore concerned that the systems for making appointments at the St Stephens Gate Medical Practice may need reviewing in particular whether there should be guidelines and/or triggers for a doctor's appointment as opposed to nurse practitioner when the appointment is for a very young child or baby.

6	**ACTION SHOULD BE TAKEN** 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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 4 February 2014. I, the Assistant 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: [redacted] (mother) [redacted] (father) [redacted] (Grandfather) [redacted] Norfolk Safeguarding Children Board Room 60 Lower Ground Floor County Hall Martineau Lane Norwich NR1 2UG

	Derek Winter (Archivist) HM Coroner for the City of Sunderland Civic Centre Burdon Road Sunderland SR2 7DN I am also 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, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	4 December 2013