REGULATION 28: REPORT TO PREVENT FUTURE DEATHS .

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Rt Hon Jeremy Hunt MP, Secretary of State for Health, Department of Health** **2. [redacted] Chair of Council, RCGP** **3. [redacted] President, RCPCH** **4 [redacted] Chair, Health Education England** **5 [redacted] Chair, General Medical Council**
1	**CORONER** I am Miss Sara Lewis, Assistant Coroner, for the coroner area of City of Manchester.
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	**INQUEST** On 9 October 2012 an inquest was opened into the death of Oliver George Hiscutt, aged 2 years 11 months. The inquest concluded on 19 March 2014. The medical cause of death was: 1a. Catastrophic Haemorrhage 1b. Retropharyngeal infection eroding into major artery 1c. Group A beta haemolytic streptococcal infection. Oliver Hiscutt's death was due to natural causes.
4	**CIRCUMSTANCES OF THE DEATH** On Friday 21st September 2012 the deceased was unwell with a suspected cold. He subsequently developed a rash and was taken to his GP on 24th September 2012, where a viral infection was diagnosed. By 26th September he had developed a stiff neck with reduced movement. There was also swelling to the neck observed by his parents. He presented to the Emergency Department at Wythenshawe Hospital where neck stiffness was noted. He was assessed and discharged with a diagnosis of viral tonsillitis. Over the next four days he did not improve with regular paracetamol. By 30th September 2013 his parents felt that he had deteriorated too much to wait for a GP appointment and again attended at the Emergency Department of Wythenshawe Hospital. He was commenced on IV antibiotics and admitted to the ward. A two day history of neck swelling and neck pain was noted. A peritonsilar abscess was queried but ENT review concluded that there was no abscess present. He showed some improvement during his admission and was changed to oral antibiotics and discharged home on 2 October 2012. On 2nd October 2012 Group A beta-haemolytic Streptococcus had been found in blood cultures and a throat swab. By 4th October 2012, he had deteriorated at home. He was eating less and appeared to be holding food in his mouth before spitting it out. On the morning of 5 October 2012 his mother discovered a large volume of vomit on his bed and pyjamas containing fresh and old blood clots. He was taken to the Emergency Department of Wythenshawe Hospital where he was readmitted and started on IV antibiotics. A swelling in the left side of the neck was identified. His

	clarity of speech deteriorated and he appeared to be in pain if moving his jaw. He developed an underbite and his jaw was protruding. He developed drooling and had difficulty swallowing. At approximately 6.00 am on 7 October he suddenly woke up and vomited a large amount of fresh blood from his mouth and nose. He had a cardiac arrest at which time he was resuscitated. He was transferred to theatre where the bleeding was stopped. He suffered a further cardiac arrest and, despite resuscitation, life was pronounced extinct at 9.30am. At post mortem it was discovered that the deceased had a retropharyngeal abscess which is entirely in keeping with the complications of a Group A beta-haemolytic streptococcal infection. An arterial structure with a completely necrotic wall was identified within the infected tissues, from where it is likely that the catastrophic haemorrhage originated.
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: Currently it is not mandatory for GPs to undertake formal paediatric / child health training. *Facing the Future (2011)* states that there are currently 10 000 GP trainees in the country and less than 25% of them will undertake any paediatric placement during their training. GP trainees who do undertake a paediatric placement during their training gain a range of educational benefits such as the development of skills in spotting the sick child, specialist management of children with long term conditions and multi disciplinary team working. The Royal College of General Practitioners and the Royal College of Paediatrics and Child Health strongly support all GPs having exposure to acute paediatrics as part of their vocational training. Offering every GP trainee a hospital post in paediatrics within the current 3 year speciality training programme is undeliverable. The Royal College of General Practitioners makes the case that there should be an enhanced 4 year programme of GP training and that all GPs should undertake specialist led paediatric training. Specialist led paediatric training will ensure that future GPs have the skills and experience they need to assess and respond effectively and safely to sick children, to better co-ordinate the care of children with long term conditions and to safeguard those at risk.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 28th May 2014. 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 [redacted] and [redacted] and to the Local Safeguarding Board. I have also sent it to [redacted] Consultant Paediatrician, University Hospital of South Manchester who may find it useful or of interest. 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	**[DATE]** **1st April 2014**	**[SIGNED BY CORONER]**