	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Ms Marianne Griffiths, Chief Executive, Western Hospitals NHS Foundation Trust** **2. [redacted] President, Royal College of Paediatrics and Child Health** **3. Department of Health**
1	**CORONER** **I am Karen HENDERSON, assistant coroner for the coroner area of West Sussex**
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 12th December 2013 I commenced an investigation into the death of Lucy Maria GOULDING, 16 years of age. The investigation concluded at the end of the inquest on 12th December 2013. The medical cause of death given was: **1a. Brain stem herniation** **1b. Hydrocephalus** **1c Pilocytic astrocytoma** **2.** My narrative conclusion was: **Lucy Goulding died from brain stem death arising from raised intracranial pressure due to a benign cystic astrocytoma in circumstances where there was a delay in investigation and diagnosis and where deterioration went unrecognised, all of which could have affected the outcome.**
4	**CIRCUMSTANCES OF THE DEATH** Lucy Goulding presented with a relatively short history of headaches to her GP who diagnosed tension headaches or migraine. Her headaches worsened substantially and her mother dialled 999 and Lucy was admitted into hospital at or around 1400 on 26th June 2013. No formal assessment, investigation or management was undertaken for her headache during her time in hospital. A referral to the community mental health team was to be made the following day when the admitting doctors planned discharge. Lucy was transferred to the paediatric ward where neurological observations were not carried out. Lucy's headache persisted and worsened despite being treated with painkillers. She collapsed and had a cardiorespiratory arrest at or around 0300, 27th June 2013. She was intubated and ventilated and an emergency CT scan found a brain tumour, which was a benign cystic astrocytoma. Lucy was transferred to the neurosurgical unit at Southampton General Hospital for emergency treatment to relieve the pressure on her brain and to remove the benign tumour but she did not recover from her collapse at Worthing hospital and Lucy was confirmed dead at 21.12 on 27th June 2013 in the neurological ITU at Southampton General Hospital.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise for concern. In my opinion there is a risk that future death 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. Lack of consultant supervision of on-call paediatric trainees or sub-consultant paediatric doctors admitting paediatric patients as an emergency into Worthing Hospital

	2. Lack of independent consultant assessment of paediatric admissions into Worthing Hospital in and outside normal working hours 3. Lack of national guidelines for assessment and investigation of headaches in children
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation: Worthing Hospital NHS Trust, Royal College of Paediatrics, and the Department of Health 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 24th March 2014. I, the coroner, may extend this 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) and to the local safeguarding board. I have also sent it to [redacted] 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: 24/01/2014** **SIGNED: Karen Henderson Assistant Coroner West Sussex** pp GrBulbeck