## **REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)**

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO:
	1. The Surgery, Chesterton, Newcastle, Staffs, ST5 7EB
1	CORONER
	I am Louise Hunt, Senior Coroner, for the Coroner area of Birmingham and Solihull.
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 12/05/14 I commenced an investigation into the death of Jack Dulson aged 9 years. The investigation concluded at the end of the inquest on 05/08/14. The conclusion of the inquest was that Jack died from natural causes due to pericarditis.
4	CIRCUMSTANCES OF THE DEATH
	Jack had been a previously fit and well young boy. He became lethargic and developed knee pain and a temperature resulting in his parents taking him to City Hospital Stoke on Trent on 07/03/14. He was diagnosed with a viral illness and discharged home. He appeared to make a recovery until the 25/03/14. At that time he was lethargic and couldn't swallow. He was seen by his GP. A blood test was arranged. This was undertaken on 27/03/14 at City Hospital. The results were available at the GP surgery on 27/03/14. They confirmed a CRP of 169 (very high and indicating infection) and anaemia. The results were not reviewed by until the family requested an appointment which took place at 17.50 on 28/03/14. At that time Jack was seriously ill and was admitted as an emergency to City Hospital where he was diagnosed with pericarditis causing a pericardial effusion. He was transferred to Birmingham Children's Hospital on 29/03/14. He had insertion of a pericardial drain on 31/03/14. He appeared to be making progress until he suffered a sudden cardiac arrest on 03/04/14. He could not be resuscitated and passed away at 22.45.
	The evidence at the inquest confirmed that earlier treatment and diagnosis would not have made a difference to the outcome.
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
	<ul> <li>(1) The GP practice had no system in place to review abnormal blood test results when they were received and to then review the patient and provide treatment.</li> <li>(2) The abnormal blood tests were only reviewed when the family arranged and insisted on an appointment – this was over 24 hours after the tests results were available.</li> </ul>

6	ACTION SHOULD BE TAKEN
	In my opinion action should be taken to prevent future deaths and I believe you 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 1 <sup>st</sup> October 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 :-
	and to the LOCAL SAFEGUARDING BOARD (as the deceased was under 18)].
	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	6 <sup>th</sup> August 2014
	[SIGNED BY CORONER]