IAN MICHAEL ARROW
Senior Coroner for Plymouth, Torbay and South Devon

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Chief Executive & Medical Director Plymouth Hospitals NHS Trust. Derriford Hospital, Plymouth**
1	**CORONER** I am IAN MICHAEL ARROW, Senior Coroner for Plymouth, Torbay and South Devon
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 07/03/2013 I commenced an investigation into the death of Ella Rose Block then aged 4 years. The investigation concluded at the end of the inquest on 06 October 2014. The conclusion of the inquest was NATURAL CAUSES. The medical cause of death was found as 1(a) Reactive Hemophagocytic Syndrome 1 (b) Sepsis due to Unidentified Pathogen
4	**CIRCUMSTANCES OF THE DEATH** The deceased had previously been seen by her GP. She was admitted to Derriford Hospital on 1 March 2013 unwell and feverish. She deteriorated over night and she sadly died on 2 March 2013.
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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] An opportunity may have been missed to provide suitable treatment. Deaths of children as a result of Sepsis are fortunately rare but as a result new qualified clinicians are not readily identifying such deaths

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6	**ACTION SHOULD BE TAKEN** I am attaching a copy of an individual case review conducted by the Royal College of Paediatrics and Child Health. I would ask you please to confirm that the recommendations are in hand. In addition, I received evidence from [redacted] at the Inquest who brought practical matters to my attention. 1. He was concerned that there was poor awareness of Sepsis amongst Junior Doctors. He particularly suggested that junior doctors receive training, i.e. a lecture on Sepsis early in their academic year preferably October before the onset of winter Sepsis. That there be some consideration given to an active poster campaign as the doctor explained to me on the basis of Lord Kitchener "Think of Sepsis" 2. He explained to me as did [redacted] that there have been organisational changes in Derriford Hospital, in particular a change of Observation Charts known as Paediatric Early Warning Score charts. It was also explained to me that there was a change n procedure in that the Observation Charts are to be reviewed at every changeover of shift. 3. It occurs to me that some paediatric doctors will be working as Locums and there would be merit in standardising the Paediatric Early Warning Score chart at least regionally so that all Locum Doctors are familiar with a standard system. To that end, I am sharing this Notice with the Minister of Health 4. I would ask you please to review the Royal College of Paediatricians and Child health recommendations together with the other practical points raised in this Report and let me know in due curse what steps have been taken. Please feel free to share this Regulation 28 Report with other Hospitals in the region as I am aware of child deaths due to Sepsis in Hospital within the region.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 01 December 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]. The Chief Executive. [redacted] The Medical Director, Plymouth Hospitals NHS Trust. [redacted] (the parents) and to the LOCAL SAFEGUARDING BOARD South West Peninsula Child Death Overview Panel (where the deceased was under 18)]. I have also sent it to Royal College of Paediatrics and Child Health, [redacted] Regional Director for Public Health and the Minister for Health 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	Dated 07 October 2014 Signature_____ Senior Coroner for Plymouth, Torbay and South Devon

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