CORONER'S OFFICE
DISTRICT OF HERTFORDSHIRE

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MR EDWARD G. THOMAS Senior Coroner
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Assistant Coroners

22 July 2014

Via email; nice@nice.org.uk

Sir Andrew Dillon
Chief Executive
National Institute of Health & Care Excellence
Level 1a City Tower
Picadilly Plaza
Manchester
M1 4BT

Your Ref: t.b.a
Our Ref: 1872-2012

Dear Sir Dillon,

Re: Yahya Ahmad KHAN, deceased

I am writing to you under the provisions of Schedule 5 (paragraph 7) of the Coroners and Justice Act 2009 which came into force in July 2013. This reenacted the provisions of the old Rule 43 of the Coroners Rules 1984. Attached to this letter is information concerning the new rules and regulations from which you will see a written response is required from you. Copies of this letter and the response received from you to be forwarded to the other interested persons properly identified at the Inquest in accordance with the list attached. I am also sending a copy of this letter to the Care Quality Commission in Newcastle and the Department of Health for their general information.

On the 10th June 2014 I concluded an inquest into the tragic death of Yahya Ahmad Khan (who I will hereafter refer to as Yahya). Please find attached a copy of the Record of Inquest from which I concluded that Yahya had died from an undiagnosed natural condition, namely acute appendicitis. I am told by experienced clinicians who attended the inquest that this condition is extremely rare in a child under the age of 2yrs and with all their wealth of experience they could only identify two cases that any of them had previously been involved with. The post mortem report showed that Yahya suffered from an acute gangrenous appendicitis with surrounding abscesses which had not caused acute peritonitis. There were multiple abscesses in the liver secondary to the infection in the appendix and there was right pleurisy.

Yahya was a very well care for contented child who had reached all his developmental milestones. He had not suffered any illnesses until he started to have diarrhoea and vomiting from the 15th July 2012. At the time his parents who lived in Hertfordshire were visiting Yahya's grandparents in Darwen in Lancashire when his temperature became raised and the extended

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family's GP in Darwen diagnosed a mild viral gastroenteritis. The symptoms including that of a raised temperature persisted so Yahya was taken by his parents to the A&E Department at Addenbrookes Hospital on Sunday the 22nd July 2012. He was seen by a junior registrar who carried out a thorough examination noting that the temperature at that point was 39.8. Yahya's abdomen was noted to be soft and there were normal bowel sounds. His findings were discussed with two more senior colleagues, one of whom was a dedicated Paediatric Emergency Medicine Specialist Registrar. The conclusion was that Yahya had suffered from a common childhood illness and a leaflet was given with a suggestion of a urine sample being tested through the general practitioner. No blood tests were carried out or other investigation took place and no urine sample was taken to the GP for testing.

Yahya's condition continued to be a concern to his parents. His mother being a doctor at the Lister Hospital attempted to discuss the matter with a Paediatric consultant on the 28th July but unfortunately she was involved in a number of critical emergencies for children. The family then took Yahya to the Lister A&E Department the next day and was seen by an out of hours doctor who referred him immediately to the paediatric team. By that time Yahya's temperature on assessment was 37.8, his throat was said to be pink and his abdomen was soft. Other examinations were normal. Again the diagnosis was made of mild simple diarrhoea and vomiting secondary to gastroenteritis. He was kept in hospital for about four hours during which he successfully passed his fluid challenge and there was no further vomiting or diarrhoea. A stool sample was obtained but unfortunately appears not to have reached the laboratory. No follow up was arranged nor were any blood or urine tests carried or scanning. Yahya's parents were not aware that the stool sample had not been tested until after his death.

Yahya's mother reported that the vomiting settled some three or four days after this second Sunday visit to hospital. She contacted the Paediatric Registrar the following day as there was a trace of pink mucus in his stool which was then resolved and generally his vomiting settled and he was having normal bowel movements together with an improvement in his temperature.

Yahya was seen by a Health Visitor on the 9th August for a developmental assessment. He was seen then to be in a little discomfort and the Health Visitor offered to postpone the developmental assessment but he cooperated. She put down the discomfort to his teething. Two days later on the 11th August Yahya collapsed at home and had to be resuscitated in the ambulance taking him to the Lister Hospital. He was not able to be resuscitated and death confirmed. The paediatrician noted an enlarged liver and enlarged spleen.

Much discussion took place at the Inquest relating to your helpful guidelines in reference to NICE clinical guidance 47 which was applicable at the time and your clinical guidance 160 which you issued in May 2013. Discussions particularly took place in relation to your references 1.5 – 8.1 (pages 28-29) and it was wondered whether it might be helpful to include in those:-

- Repeated visits to healthcare professions
- Previous consultation/s should be considered in any decision as to what tests should be carried out and whether or not to admit to hospital.

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It was also debated as to whether it would be helpful to include also in the diagnosis possibilities, surgical conditions, and possibly the very rare appendicitis in under 2yr olds made a specific consideration.

Both consultations in the A&E Departments were on a Sunday when it would be very difficult to obtain GP records and perhaps in except in an emergency even records from other hospitals. An issue that has been raised with me on previous occasions is the fact that particularly at weekends A&E Departments have difficulties as there is no unified electronic patient records system.

I had the benefit of an extremely helpful serious incident investigation carried out by a Consultant Paediatrician together with expert advice from a Consultant Paediatric Surgeon from Great Ormond Street Hospital. Both emphasised the need to take into account that Yahya's prolonged illness should have been seen as a linked process rather than a series of separate events with different consultations in different organisations. Collectively over a period of time such symptoms should have considered the use of tests such as blood tests and scanning and *ensuring* that they are carried out. The reviewer felt that the use of teething to account for such symptoms should be discouraged.

Yahya's death was so tragic as if his appendicitis had been diagnosed there is no doubt it would have been successfully surgically removed.

I hope that my drawing your attention to this case and to some of the comments made will be helpful and I look forward to hearing on your comments in due course. As you will note I will be sending a copy of this letter to the CQC as they have an inspection role in hospitals and also to the Department of Health particularly over the issue of having a uniform electronic patient records system.

The rules require a response within 56 days of receipt of this letter which I calculate as the 16th September 2014. Should you have difficulties complying with this timescale please contact me beforehand with your reason in order for me to consider whether an extension is applicable.

Many thanks for your anticipated assistance in this matter.

Yours sincerely

Edward Thomas
H M Coroner

CORONER'S OFFICE
DISTRICT OF HERTFORDSHIRE

Regulation 28

I am reporting this matter to you in accordance with Regulation 28 which is a duty under paragraph 7(1) of Schedule 5 of the Coroner and Justice Act 2009. This Rule provides that where the evidence of an Inquest gives rise to a concern that circumstances creating a risk of other deaths will occur or will continue to exist in the future and in the coroner's opinion actions should be taken to prevent the occurrence or continuation of such circumstances or to eliminate or reduce the risk of death created by such circumstances, the coroner may report the circumstances to a person who may have power to take such action.

In accordance with Regulation 28, a copy of this report is being sent to the Chief Coroner and all other proper interested parties identified at the Inquest. Your response to this report will be shared with those listed.

The Chief Coroner may send a copy of the report and response to any person whom the Chief Coroner believes may find it useful, or of interest, in addition he may publish a full copy or summary of the report in response (unless I have decided otherwise in response to a written representation about the release and publication of your response).

Regulation 28 requires that you give a written response within 56 days of the day the report is sent. If you are unable to respond within that time, you may apply to me for an extension. The response is to contain details of any action that has been taken or which it is proposed will be taken whether in response to this report or otherwise, or an explanation as to why no action is proposed.

If there are circumstances where you do not want your full response to be shared with the copy recipients referred to above, or for a copy of it to be published, you may make a written representation to me at the time of giving your response. Instead of releasing or publishing your full response it may be possible to share or publish a summary in accordance with Regulation 28.