REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **(1) Ian Cumming OBE | Chief Executive | Health Education England (HEE)** **(2) [redacted] | President | College of Emergency Medicine (CEM)** **(3) [redacted] | President | Royal College of Paediatrics and Child Health (RCPCH)**
1	**CORONER** I am R Brittain, Assistant Coroner for Warwickshire
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** The investigation into the death of Evelyn Mary Smith concluded at the end of the inquest on 5 September 2014. The cause of her death was Acute Ulcerative Laryngotracheobronchitis; the conclusion of the inquest was narrative (copy attached).
4	**CIRCUMSTANCES OF THE DEATH** Miss Smith was 7 years old at the time of her death on 13 September 2013. She did not have a significant past medical history. The illness which resulted in her death began on 11 September 2013. She awoke in the early hours of 12 September with difficulty in breathing. This prompted her mother to take her to the Accident and Emergency (A&E) Department at Warwick Hospital (part of South Warwickshire NHS Foundation Trust). She was seen by a Foundation Year 2 (FY2) doctor who had 8 weeks undergraduate and no postgraduate experience in paediatrics. This doctor diagnosed Miss Smith as having 'viral croup' and prescribed steroid medicine (Dexamethasone). Miss Smith was discharged after the FY2 doctor discussed her case with a more senior 'Specialty A&E Registrar'. Both doctors were reassured that her vital signs were improving, although she did have a persisting fever and a heart rate above the normal range. Later on the 12 September 2013 Miss Smith's family arranged for her to be reviewed at her GP practice because of ongoing concerns. She was seen by an Advanced Nurse Practitioner, who diagnosed tonsillitis and prescribed antibiotics. Her respiratory rate, along with other vital signs, were not documented as part of this consultation. On 13 September 2013 Miss Smith remained unwell and was taken back to her GP. She was seen by a doctor who again diagnosed viral croup. Her GP accessed a 'clinical mentor' tool on the practice computer system, which highlighted a scoring algorithm to classify the severity of croup. Miss Smith was scored as having moderate croup which,

	the scoring classification suggests, warranted admission to hospital. However, after treatment with a Salbutamol nebuliser (instituted because of a recent insect sting), Miss Smith's GP felt that she had improved and prescribed a further course of oral steroid medication (Prednisolone). She was not admitted to hospital and returned home. Whilst at home later on 13 September, Miss Smith suffered an acute deterioration in her breathing, at which point she had a cardiac arrest. Despite the institution of early resuscitation and rapid transfer to hospital by paramedics, it was not possible to revive her and she was pronounced dead at Warwick Hospital. A *post-mortem* examination demonstrated the presence of a virus (Parainfluenza Virus Type 2) and a bacterium (*Staphylococcus Aureus*) as infectious organisms, which resulted in Acute Ulcerative Laryngotracheobronchitis.
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 may occur, unless action is considered. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – (1) The care provided to Miss Smith was reviewed by an independent paediatrician, who raised concerns regarding the paediatric experience of the FY2 doctor in A&E. His concern was that, whilst the care provided was not manifestly inappropriate or incorrect, he considered that discussion with the paediatric team may have prompted a longer period of observation and consideration of non-viral causes of croup-like signs. I share his overarching concern that a doctor, relatively inexperienced in paediatrics, should be the only clinical contact for a child taken to A&E. I heard from the Hospital Trust that mandating all FY2 doctors to have postgraduate experience in paediatrics, before they were allocated to work in A&E, might have significant resource implications and may not be feasible.
6	**ACTION SHOULD BE TAKEN** In my opinion, consideration should be given as to whether action is required to prevent future deaths. I believe the addressees have the power to make such a consideration and take appropriate 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 7 November. 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 (a) The Smith family, (b) South Warwickshire NHS Foundation Trust and (c) Miss Smith's General Practitioners 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	**12 September 2014** **Assistant Coroner R Brittain**