REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: [redacted] Out of Hours Clinical Manager, Bridgewater Community Healthcare NHS Trust**
1	**CORONER** I am John Pollard, senior coroner, for the coroner area of South Manchester
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 the **11th April 2014** an investigation into the death of **Mikey James Hornby** dob 31st March 2014 was started by the Coroner for Cheshire and subsequently transferred to me. The investigation concluded on the **12th December 2014** and the conclusion was one of **Natural Causes contributed to by neglect**. The medical cause of death was **1(a) E-Coli Neonatal Sepsis and meningitis**
4	**CIRCUMSTANCES OF THE DEATH:** **Mikey and his mother were discharged from hospital after his birth at around 15.00 hours on the 1st April 2014. From the outset he was a fussy eater. On the 6th April he attended the hospital for his 'heel-prick' test and whilst there it was brought to the attention of the staff that his umbilical-cord clip was 'digging into his tummy'. The nurse advised that he should be seen by his GP. There were no available appointments so his father took him to the OOH GP service at 22.30 hours that night. They attended at the OOH surgery at the hospital and Mikey was seen by a doctor straight away who prescribed Fucidin Cream. On the 10th April at approximately 21.00 hours Mikey's breathing became strange and he was taken to the OOH service where he was examined by the doctor who diagnosed a throat virus and prescribed "Paracetamol". By the time the consultation had ended the hospital pharmacy, and all others known to the parents of Mikey, was closed for the night. Mikey was again taken home and placed in his Moses basket. At 05.15 hours the next morning he was found lifeless in his basket. He was rushed to hospital but could not be saved.**
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. – **1. On the first attendance at the OOH service, the attending staff having seen the infected umbilical cord, did not immediately send Mikey to the Hospital (as would have been the correct procedure according to the Consultant Lead Paediatrician who gave evidence to me.)**

	2. **On the second attendance the doctor failed to appreciate the seriousness of the situation and at 10.45 at night sent the child home with a prescription for analgesia (which could not be filled until the following day in any event). The Consultant Paediatrician gave evidence to me "that there was a very high probability that he would have survived' had he been sent to the hospital at this time as he could and would have been administered an intra-venous anti-biotic.** 3. **If there is any realistic possibility of the condition being meningitis, the child should have been immediately admitted to the hospital.** 4. **The GP covering the surgery that night indicated that they do not have the facility to take a simple blood test. If this is the case, then they should utilise the adjacent facilities at the Emergency Department of the hospital.**
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. **There is a very clear training need identified here, in relation to the appreciation of this type of occurrence with very young children.**
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely **by 10th February 2015**. 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 namely [redacted] **(parents of Mikey)**. I have also sent it to [redacted] (Consultant Paediatrician), Mr **Nicholas Rheinberg** (HM Senior Coroner for Cheshire) and to the **Care Quality Commission** 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	**16.12.14** **John Pollard, HM Senior Coroner**