Nicola Jane Mundy
Senior Coroner for South Yorkshire (East District)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Mr Mike Pinkerton, The Chief Executive** Doncaster And Bassetlaw NHS Foundation Trust Doncaster Royal Infirmary Armthorpe Road Doncaster DN2 5LT
1	**CORONER** I am Nicola Jane Mundy, Senior Coroner for South Yorkshire (East District)
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 22/05/2015 I commenced an investigation into the death of Marc Jason Stephen Poole, age 6. The investigation concluded at the end of the inquest on 1st February 2016. The conclusion of the inquest was a Narrative conclusion: Marc Jason Stephen Poole was admitted to the Doncaster Royal Infirmary on 16 May 2015 with a suspicion of infection with no focus. Prolonged assessment and investigations delayed provision of antibiotic therapy. Had antibiotics been commenced on 16 May 2015 it is likely that MJ would have survived. He died in Sheffield Children's Hospital on 18 May 2015 from effects of pneumococcal septicaemia. The cause of death was Septicaemic shock due to pneumococcal septicaemia due to Sinusitis
4	**CIRCUMSTANCES OF THE DEATH** Mark Jason Stephen Poole (MJ) was admitted to the Doncaster Royal Infirmary on the 16th May 2015 having being unwell all day complaining of a headache, vomiting and being unable to walk. He was admitted to hospital where infection was suspected and investigations commenced. A decision was made not to commence antibiotics on admission on 16 May to allow investigations to take place. Whilst bloods could have been taken on admission, there was no clear direction that they should have been and indeed these were taken in the early hours of the following morning. Antibiotics were not commenced at that time as there was a wish to undertake a chest x ray and urine sampling in an effort to first find a focus of infection. Antibiotics were to be commenced after those steps had been undertaken. Following completion of initial investigations at around 16.40 on the 17th May, antibiotics were commenced. During the course of this afternoon MJ remained unwell. The clinical evidence was that MJ's observations were stable save for the odd spike in temperature. The family's evidence was that MJ remained very unwell. The observation chart was not completed as it should have been and calculation of warning scores were inaccurate on more than one occasion. As it was, antibiotics were commenced at 16.40 on 17th May after a urine sample had been taken and tested for. MJ also developed mottling on his lower limbs which faded but returned. There was insufficient communication regarding the appearance and nature of the rash. There was delay in the elevated CRP level for bloods taken that afternoon being communicated to the treating doctors and acted upon. MJ became critically unwell between 21.30 hrs and 22.40 hrs leading to the crash team being called, EMBRACE attended with a view to transferring MJ to the Sheffield Children's Hospital. At the Children's Hospital he received support from the intensivist. These efforts proved futile with him passing away in the early evening of the 18th May.

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	On the 18th May the results of the initial blood test came back which revealed the presence of streptococcus pneumonia.
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) Poor communication on a number of levels Insufficient discussion with the parents regarding history, insufficient weight attached to the information they did provide at the time of admission and subsequently. Absence of any protocols of guidance as to how best to communicate with children with disabilities such as autism as MJ had. Communications between staff were poor, HCAs to nurses, nurses to doctors and between junior doctors and senior doctors. Ineffective communication of microbiology results which had been phoned through to the ward but not immediately passed on to those who needed to undertake assessment. (2) PAWS The observation chart was poorly completed. There were occasions where incorrect scoring had been documented understating MJ's condition at that time. This was a form and source of information said to have been heavily relied upon but no clear protocols for doctors to regularly review and assess. It would seem further training is required to ensure accurate completion of this form and accurate scoring. (3) Sepsis in Paediatrics It is clear that consideration should be given to developing a protocol and guidance for those treating children. A paediatric screening tool needs to be provided. There needs to be clear explanations of the terms septic, sepsis, septic shock, septicaemia, bacteraemia. These terms were used interchangeably. It needs to be made clear to staff the signs they should be looking out for and how these might be responded to. (4) Dissemination of key information and medical updates There needs to be a review of the systems currently in place for disseminating such information. I was not reassured from the evidence I heard that the current system is effective in that regard or fully understood by staff at the trust. (5) Poor record keeping Even when a ward is busy, it is imperative that clear records are made of significant events or developments. There were a number of occasions where no record was made at all

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, Mr Mike Pinkerton, The Chief Executive has 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 **28 March 2016**. 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] and [redacted] Messrs Langleys Solicitors, Sheffield Children's Hospital and to the LOCAL SAFEGUARDING BOARD. 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 2 February 2016 Signature_____ Senior Coroner for South Yorkshire (East District)

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