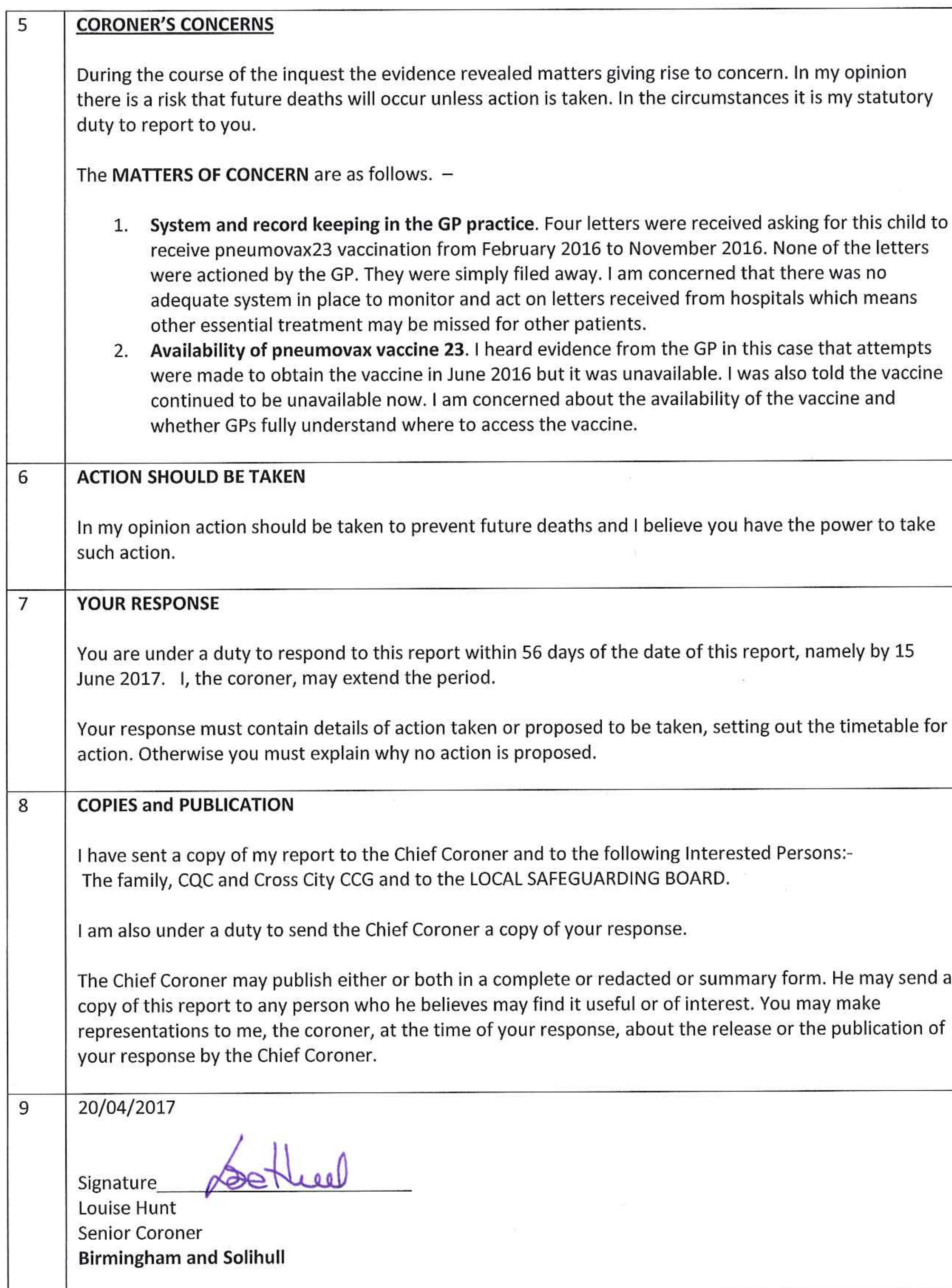
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. [redacted] 2. NHS England
1	**CORONER** I am Louise Hunt Senior Coroner for **Birmingham and Solihull**
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 21/12/2016 I commenced an investigation into the death of Johan Stone Pambou. The investigation concluded at the end of an inquest on 19th April 2017. The conclusion of the inquest was: Died from pneumococcal septicaemia contributed to by not receiving a necessary pnuemovax 23 vaccination. His death was contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** The deceased suffered from sickle cell disease. On 07/12/16 at 02.47 he was admitted to the emergency department at Birmingham Heartlands Hospital with severe abdominal pain and joint pains. He was initially reviewed by a junior doctor who suspected an abdominal sickle cell crisis and he was admitted at 08.55 to the paediatric assessment unit for observation. He was seen by the consultant at 10.30 who diagnosed a sickle cell crisis and he was given morphine for pain relief. There was discussion with Birmingham Children's hospital about whether he required a transfusion and a decision was initially made to arrange a transfusion as he was pale and his HB was just below the baseline. He was transferred to HDU at approximately13.50. He became drowsy following the morphine and a further review was undertaken at 16.20. A decision was made to reverse the morphine. Johan became more alert but continued to be distressed and in pain so a lower dose of morphine was then given. At 16.50 the CRP result was received and the level was 433. At this time Johan was tachycardic and his HB had dropped to 49. At18.40 he had continued to deteriorate and a repeated HB confirmed a result of 48. The critical care outreach team was called to assess and support him. Antibiotics were started at 18.50 having been prescribed at 18.00. He acutely deteriorated at 18.40. A blood transfusion was started at 19.35. Arrangements were made for him to be transferred urgently to Birmingham Children's hospital. He was admitted to ITU where he was diagnosed with pneumococcal septicaemia. He died despite further treatment on 11/12/16. Sickle cell patients are recommended to have pneumovax 23 vaccination after the age of 2. Four letters were sent to the deceased's GP to request this in February 2016, March 2016, August 2016 and November 2016. Attempts were made to obtain the vaccine in June 16 when the vaccine was said to be unavailable. No further attempts were made to find and give the vaccine before Johan became unwell in December 2016. Based on information from the Deceased's treating clinicians the medical cause of death was determined to be: 1a PNEUMOCOCCAL SEPTICAEMIA 2. SICKLE CELL DISEASE



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. **System and record keeping in the GP practice**. Four letters were received asking for this child to receive pneumovax23 vaccination from February 2016 to November 2016. None of the letters were actioned by the GP. They were simply filed away. I am concerned that there was no adequate system in place to monitor and act on letters received from hospitals which means other essential treatment may be missed for other patients. 2. **Availability of pneumovax vaccine 23**. I heard evidence from the GP in this case that attempts were made to obtain the vaccine in June 2016 but it was unavailable. I was also told the vaccine continued to be unavailable now. I am concerned about the availability of the vaccine and whether GPs fully understand where to access the vaccine.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 15 June 2017. 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:- The family, CQC and Cross City CCG 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	20/04/2017 Signature______________ Louise Hunt Senior Coroner **Birmingham and Solihull**