**Eastern Area of Greater London Coroners**

**MISS N PERSAUD**
**SENIOR CORONER**

**Walthamstow Coroner's Court Queens Road Walthamstow E17 8QP**
Telephone 020 8496 5000 Email coroners@walthamforest.gov.uk

REF:4597

22nd January 2018

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO: Dr Alistair Chesser, Chief Medical Officer, Barts Health NHS Trust** |
| 1 | **CORONER**<br><br>I am Miss N Persaud Senior Coroner for Eastern Area of Greater London |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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.<br>http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7<br>http://www.legislation.gov.uk/uksi/2013/1629/part/7/made |
| 3 | **INVESTIGATION and INQUEST**<br><br>On 28/11/2016 I commenced an investigation into the death of Caliel Arlington SMITH-KWAMI. The investigation concluded at the end of the inquest 19th January 2018. The conclusion of the inquest was a narrative conclusion:<br><br>*Caliel Arlington Smith-Kwami suffered from a profound hypoglycaemic episode around 28 hours following his birth. As a result of this, it is likely that he sustained a hypoglycaemic injury to his brain. He was admitted to hospital and tests were undertaken, in hospital, to determine the cause of the hypoglycaemia. Caliel was discharged from hospital before key test results were obtained. The results of these tests, when later received, revealed a likely diagnosis of hyperinsulinism. These results should have been chased and received before discharge. Had they been received it is likely that Caliel would have undergone further investigation, monitoring and treatment by a specialist team.*<br><br>*The health visitor attending Caliel on 4 August 2016 did not make contact with the NICU or the community midwives. There was a missed opportunity for the health visitor to highlight the outstanding test results and to ensure the involvement of the community midwives.*<br><br>*Caliel did not undergo any specialist investigation, monitoring or treatment. He passed away on the 17 August 2016 from persistent neonatal hyperinsulinaemic hypoglycaemia. Had Caliel been referred to the specialist team, as he should have been, on the balance of probabilities his death at that time would have been avoided.* |
| 4 | **CIRCUMSTANCES OF THE DEATH** |

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| | See narrative conclusion. |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>(1) The insulin results were delayed, due to a fault with the analyser. Clinicians were not notified by the lab, that the analyser was not functioning. No alert was sent out. Contingency plans could have been put in place, to ensure that alternative arrangements were made for the test to be analysed before Caliel was discharged from hospital. The independent expert was critical of the lab's failure to notify clinicians.<br>(2)Test results do not appear to have been chased up before Caliel's discharge from hospital. It was unclear from the evidence who had the responsibility for chasing up test results prior to discharge.<br>(3)The results of the amino acid profile, which raised the possibility of hyperinsulinism were sent through to the electronic record system on the 9 August 2016. It does not appear that any clinician was aware of this result prior to Caliel's death. The Consultant in Charge of Caliel's care stated that there is no system in place with the electronic record system for highlighting to clinical staff that results are ready. He stated that when paper records were in place, clinicians would result the paper result, but this notification has now been lost.<br>(4) The independent expert stated that in the absence of the insulin and amino acid profile results, a ketone test might have assisted with the diagnosis. He stated that ketone tests can be obtained at the bedside and that this has recently been introduced within his Trust. No witness at the inquest was able to confirm whether the bedside ketone test was available within Barts Health NHS Trust. |

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| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 20 March 2018. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons – [redacted] (Caliel's mother) and [redacted] (on behalf of East London Foundation Trust). I have also sent it to the CQC and to Mr Matthew Cole (Director of Public Health), who may find it useful or of interest.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | 22/01/2018<br><br>Signature  <br>Miss N Persaud Senior Coroner **Eastern Area of Greater London** |