REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Practice Manager Grange Clinic 34 Westfield Avenue Newport NP20 6EY** **2. Ms Judith Paget Chief Executive Aneurin Bevan University Health Board St Cadoc's Hospital Lodge Road Caerleon NP18 3XQ**
1	**CORONER** I am Wendy Ann James, acting senior coroner, for the coroner area of Gwent
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 03/02/15 David Thomas Bowen commenced an investigation into the death of ELLIE MAY CLARK (dob 02/01/10). The investigation concluded at the end of the inquest on 26/02/18. The conclusion of the inquest was that Ellie May Clark died from natural causes where the opportunity to provide potentially lifesaving treatment was missed. The medical cause of death being: 1 (a) Bronchial Asthma
4	**CIRCUMSTANCES OF THE DEATH** Ellie was a child with a history of severe asthma, who had been admitted to hospital on several occasions as a result of this condition. Ellie's consultant had written to her doctor at Grange Clinic ("the surgery"), advising that she was at risk of another episode of severe/life threatening asthma. Suffering with a wheezy chest, Ellie attended an appointment with a doctor at the surgery on 22/01/15, where she was told her condition was not severe enough to be prescribed steroids, but she should continue using her asthma pumps and be brought back to the surgery should her condition deteriorate. On 26/01/15 Ellie became ill in school. Her mother [redacted] contacted the surgery to request a home visit as Ellie was unable to walk, and she had no form of transport and was also caring for her 8 week old daughter. This request was refused, but Ellie was triaged by the on call doctor to assess if an emergency appointment was necessary. Over an hour later, a receptionist telephoned [redacted] to offer an emergency appointment 25 minutes later. [redacted] immediately recognised she would struggle to make the appointment on time, but she was not offered an alternative appointment and was told not to be late. [redacted] and Ellie arrived at the surgery a few minutes late and the doctor refused to see Ellie ,as she was late ,without making any clinical assessment, without asking if the on call doctor could see her or without offering any advice on what [redacted] should do if Ellie's condition worsened. [redacted] was told to bring Ellie back the following day. [redacted] returned home with Ellie, who then died later that evening.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could 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) The lack of an effective and robust care plan. No one clinician was allocated to oversee the long-term management and care of Ellie's medical condition. She was dealt with by three different doctors at the surgery within a period of 5 days leading up to her death. (2) Ellie was turned away from an emergency appointment for being late without any clinical assessment or safeguarding advice being given. (3) A delay in Ellie being triaged for an emergency appointment resulting in insufficient notice being given to [redacted] to enable timely attendance at the appointment. (4) The lack of an effective and robust triage system. The receptionist who spoke with [redacted] on the telephone and the doctor who triaged Ellie were different to the receptionist [redacted] spoke with at the surgery and the doctor with whom the emergency appointment was booked. Furthermore, the triage notes were not made available to the doctor in readiness for the emergency appointment. (5) A note that Ellie had severe/life threatening asthma was not placed on her medical notes in a prominent position. (6) Support staff did not feel they would be supported if they challenged a doctor's decision or sought a second opinion.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 30/04/18.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: Harding Evans solicitors, RadcliffesLeBrasseur solicitors and to the LOCAL SAFEGUARDING BOARD. I have also sent it to HEALTHCARE INSPECTORATE WALES 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	**6th March 2018** W A James. **Acting Senior Coroner (Gwent)**