REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Secretary of State for Health, the Chief Executive of NHS England and the Mayor of Greater Manchester
1	CORONER I am Alison Mutch, 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 27th July 2016 I commenced an investigation into the death of Novia Emilia Delima. The investigation concluded on the 17th April 2018 and the conclusion was one of narrative: Died of the recognised complications of sepsis contributed to by neglect. The medical cause of death was Neonatal Herpes Simplex (Type II), E coli septicaemia
4	CIRCUMSTANCES OF THE DEATH Novia Emilia Delima's mother brought her to Tameside General Hospital on 25th July 2016 at 01:48 because she had two episodes of blood in her nappies, was sleepy and not feeding properly. At 02:03 Novia was triaged using the Manchester triage tool. The system identified her as orange category requiring she see a doctor within 10 minutes. A junior doctor saw her about 05:35, three and a half hours after triage. In the intervening period basic observations but no tests were carried out and no treatment commenced. Further blood had been seen in the nappy. On examination, blood was seen coming from the rectum. Transfer was made to the Paediatric department; Novia arrived there at 06:30, four and a half hours after her arrival at Tameside General Hospital. She was very unwell. Sepsis was identified. Treatment was given including antiviral and antibiotic medication. Novia continued to deteriorate and died at 12:03 at Tameside General Hospital. She had died from a combination of neonatal herpes simplex and E coli septicaemia.
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. The Trust had adopted the Manchester triage system but due to demand on the ED the time identified through the triage system could not be met. The Manchester triage tool is widely used but the inquest heard that often across EDs the targets set by the triage tool are not met; 2. The inquest heard that very young babies present significant challenges in diagnosis and early clinical input by a clinician experienced in dealing with young children was important. The trust had brought in significant changes to how it dealt with paediatric cases in ED since the death of Novia. This includes early clinical involvement of a paediatric clinician for babies between 0- 6 months due to their recognition of challenges of diagnosis in very young children. The inquest heard that not all trusts, nationally, have systems that ensure very young children are seen by a paediatrician at an early stage particularly in an OOH situation. 3.on the night in question the inquest heard that a consultant was on call for ED but was not called in despite the significant delays in ED. The inquest heard that the ED on call consultant arrangements meant that long wait times would not in themselves trigger on call consultants being asked to attend 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.
7	YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by 15th June 2018. 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] Mother of the deceased, 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	Alison Mutch OBE HM Senior Coroner 20/04/2018