ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Chief Executive, Chelsea & Westminster Hospital** 2. [redacted] **c/o Medical Protection Society**
1	**CORONER** I am Philip Barlow, assistant coroner, for the coroner area of Inner South London
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 29 November 2017 I commenced an investigation into the death of Edward Joyce, age 17 months. The investigation concluded at the end of the inquest on 4 May 2018. The conclusion of the inquest was: **Medical cause of death**: 1a) Septic Shock 1b) Infected burns. **How, when and where the deceased came by his death**: Edward Joyce ("Eddie"), age 17 months, suffered an accidental burn on 19 November 2017 and was treated at Chelsea & Westminster Hospital. On 21 November he was seen by his GP and found to have a temperature of 38.9C. This reading did not trigger a referral back to hospital. On 22 November Eddie's condition significantly deteriorated. He was taken to University Hospital Lewisham where he died despite prolonged attempts at resuscitation. **Narrative conclusion**: Edward Joyce died after developing septic shock from an accidental scalding injury.
4	**CIRCUMSTANCES OF THE DEATH** Eddie was admitted overnight at Chelsea & Westminster hospital and went home on 20 November. His parents were given an information leaflet and an appointment to be seen again on 23 November. The information leaflet states that a child may need to be seen sooner if they show a fever above 38°C or vomiting. On 21 November Eddie's mother took him to the GP where he was diagnosed with an ear, throat and eye infection. During the appointment his temperature was noted to be 38.9°C. After this appointment Eddie's mother telephoned the paediatric burns unit at Chelsea & Westminster. Her evidence was that she reported the temperature reading at the GP of 38.9°C, and that the temperature had now come down to 37.6°C. The record of this telephone call recorded that the temperature was "37.6 °C - no higher" and that there had been one small vomit. Neither the GP nor the hospital nurse told Eddie's parents to bring him back to hospital. On 22 November Eddie became severely unwell. His parents telephoned Chelsea & Westminster again and were told to take him to their local A&E department. He collapsed as they arrived and died despite attempts at resuscitation.
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. – The evidence at the inquest was that a temperature reading above 38°C following a burn to a young child is highly concerning, and could be an early sign of septicaemia and toxic shock syndrome. (1) The temperature reading of 38.9°C at the GP did not trigger an urgent referral to hospital. (2) Eddie's mother was clear that she reported this temperature reading to the nurse at Chelsea & Westminster when she telephoned soon after the GP appointment. This reading is not recorded in the telephone note and the parents were not told to bring Eddie back to hospital. (3) The evidence was that scalding injuries amongst children are very common but that toxic shock syndrome is very rare. In their evidence the hospital witnesses helpfully considered whether the information leaflet could be reviewed so as to assist other health professionals who may be less aware of the potential significance of high temperature following a burn and the availability of 24 hour telephone advice from the burns unit.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/or 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 6 July 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: [redacted] The Local Safeguarding Board (because the deceased was under 18) 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	**9 May 2018** **Philip Barlow**