IAN MICHAEL ARROW
Senior Coroner for Plymouth, Torbay and South Devon

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **NHS England and NHS Digital.**
1	**CORONER** **Ian Michael ARROW, Senior Coroner for Plymouth, Torbay and South Devon**
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** An Inquest was heard by me commencing on 1 November 2016 concluding on 1 February 2019. The deceased was a six year old boy who became ill during the morning of Saturday 10 October 2015. He deteriorated over that weekend. On the balance of probability the deceased had, by the afternoon of Saturday 10 October, developed an intussusception of his bowel. During the morning of Monday 12 October 2015 his father sought medical advice from telephone service NHS 111 and from his General Practitioner's surgery. His father, in particular, spoke to a 111 call handler at 8.45 and gave an explanation of the child's condition. Until the deceased's father's last contact with NHS 111 at 13.54 on 12 October, the deceased's condition went unrecognised as being a life threatening condition. On the balance of probability therefore there were several missed opportunities for him to receive life saving treatment. In particular it is more likely than not that, had his condition been recognized and he had received treatment at 8.44, his life might have been preserved. By the time the seriousness of his condition was recognised at 13.54 it was less likely that his life could be preserved. He suffered a cardiac arrest. Following the cardiac arrest he was transferred to Derriford Hospital where he was sadly confirmed deceased in the Emergency Department shortly after his arrival on 12 October 2015.
4	**CIRCUMSTANCES OF THE DEATH** Narrative Conclusion as set out above
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. Following the inquest I received submissions that without changes in the NHS Pathways the 111 call handlers will not be adequately assisted by the Pathways to recognise the acutely unwell child, in particular: i at the conclusion of the inquest there was no question within the NHS Pathways questionnaire concerning cold hands and feet for children aged over five

	ii at the time of the conclusion of the inquest the question regarding green vomit, asked in respect of children over five, had an inappropriately high threshold (that is required severe pain for more than four hours before the question was engaged) and would not have been activated in Sebastian's case iii there has no indication NHS Pathways/NHS Digital have reviewed the support arrangements for non-clinically qualified call advisors to refer unusual cases to clinically qualified colleagues iv at the time of the conclusion of the inquest NHS Pathways' questions did not allow a meaningful assessment of pain in a child; that is to say questions about severity of pain and ability of a child to communicate such pain should be reviewed at national governance level One expert at the Hearing expressed the view that three contacts with medical providers about one concern should instigate a face to face meeting between patient and clinician. Those providing health care are asked to review the need for a failsafe mechanism whereby, when there is a repeated enquiry regarding the same complaint over a child's health within a period of time, there is a rapid assessment to determine whether or not that call requires urgent escalation to a review by an appropriate clinician and, where appropriate, a face to face meeting between the patient and an appropriate clinician.
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 by reviewing the present systems and protocols in place to assist in particular parents seeking assistance for ill children. Please carry out such a review and respond to me with the results of your review.
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 August 2019. 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 Hibberd family; [redacted] Chaddlewood Surgery; NHS England; NHS Digital; South West Ambulance Service; South West Ambulance Service NHS Foundation Trust.** [and to the LOCAL SAFEGUARDING BOARD (where 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	Dated 11 June 2019 Signature_____