



M. E. Voisin
Her Majesty's Senior Coroner
Area of Avon

16th December 2019

REF: 12525


	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>1. University Hospitals Bristol NHS Trust 2. Torbay and South Devon NHS Foundation Trust</p>
1	<p>CORONER</p> <p>I am Dr Simon Fox QC, Assistant Coroner for Area of Avon</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 02/11/2018 an investigation into the death of Alice Marie Sloman was commenced. The investigation concluded at the end of the inquest on 16th December 2019. The conclusion of the inquest was a narrative conclusion as follows:</p> <p>Alice was born with a mitochondrial disorder resulting in her developing cardiomyopathy, skeletal myopathy, short stature and Autistic Spectrum Disorder. Her medical management was lacking in that investigations to diagnose her underlying condition were not undertaken. As a result her cardiomyopathy was not diagnosed and she died from complications of a routine general anaesthetic.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Three days before her death Alice underwent a routine general anaesthetic for an MRI scan. The medical staff were unaware that she had a cardiomyopathy. The anaesthetic precipitated a cardiac decompensation from which she never recovered.</p>
5	<p><u>CORONER'S CONCERNS</u></p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows. –</p>

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The evidence demonstrated that Alice was under the care of a consultant community paediatrician, a consultant general paediatrician with an interest in endocrinology and a consultant paediatric endocrinologist presenting with a number of conditions (Growth hormone deficiency, Autistic Spectrum disorder, developmental delay, visual impairment, mobility impairment, poor coordination/dyspraxia and hypermobility) over a 9 year period but was not referred for investigation of an underlying disorder, specifically a clinical geneticist's opinion, despite her parents requesting this on at least 2 separate occasions which are documented and despite such facility being readily available in Exeter. The evidence demonstrated that as a result her underlying condition, and specifically a serious cardiomyopathy, went undiagnosed resulting in her dying unexpectedly and prematurely as a result of a routine general anaesthetic.

6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 12th February 2020. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the chief coroner and to the following interested persons(the family) and to the LOCAL SAFEGUARDING BOARD (where the deceased was under 18). I have also sent it to HSIB and the CQC who may find it useful.</p> <p>I am also under a duty to send the chief coroner a copy of your response.</p> <p>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.</p>
9	<p>16/12/2019</p> <p>Signature </p> <p>Dr Simon Fox QC, Assistant Coroner Area of Avon</p>