

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO</p> <ol style="list-style-type: none">1. Professor Sir Brian Keogh National Medical Director NHS England Rm 504 Richmond House Whitehall London SW1A 2NS2. Professor Ian Cummings OBE Health Education England 1st Floor Blenheim House Duncombe Street Leeds LS1 4PL3. Sir Andrew Dillon CBE National Institute for Clinical Excellence Midcity Place 71 High Holborn London WC1V 6NA
1	<p>CORONER</p> <p>I am Dr Shirley Radcliffe for the coroner area of Inner West London</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.</p>
3	<p>INVESTIGATION</p> <p>On 15th and 16th March 2017 an inquest was held touching the death of Mr Michael Uriely and concluded on 16th March 2017 with a narrative conclusion.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Circumstances of death</p> <p>Michael Uriely was diagnosed with asthma at the age of 2 ½ years. His asthma started to deteriorate during 2014 when he needed six courses of oral prednisolone for asthma attacks and then further during 2015. In the seven months before Michael's tragic death, his asthma, was uncontrolled, difficult to control, and probably severe. Furthermore, there were a number of missed opportunities by health professionals during these seven; had these been managed differently according to the NRAD recommendations and the BTS/SIGN guidelines, the outcome might have been altered. From the medical records, it seems that no single clinician took overall responsibility for ensuring continuity and the ongoing management of Michael's asthma; there was</p>

no evidence of an ongoing coherent plan for the management of this child's chronic 'at-risk' condition. Despite Michael's high risk status, he was not referred to or seen by a specialist respiratory paediatrician, which was a clear recommendation in the NRAD report.

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CORONER'S CONCERNS

After reading the letter from the LFB I share their concerns in relation to potential inadequacy of fire risk assessments.

The **MATTERS OF CONCERN** are as follows. –

- 1) The care management and treatment of this child during his final year of life with an exacerbations of asthma was centred solely on treating the immediate presentation as an isolated acute event seeking its stabilisation and returning him to the care of his family.
- 2) There was:-
 - i) No co-ordinating record of these occasions.
 - ii) No analysis of the acute episodes in context with his chronic asthma condition.
 - iii) No appreciation of the underlying severity and analysis of the level of medication prescribed.
 - iv) No appreciation of the risk factors of near fatal or fatal asthma evident in this child.
 - v) No appreciation of the deteriorating nature of his asthma.
- 3) Despite the presence of a significant number of health care professionals involved in his care, no single individual assumed management for his care overall.
- 4) In the absence of no one individual assuming responsibility for his care there was no plan directed towards his long term management and care identifying the chronic nature of his condition, seeking a sustained and balanced level of treatment, control.
- 5) In and of itself the death of this child demonstrates a profound and woeful indication of the lack of understanding of how this condition, its recurring nature can and should be managed by someone with the proper training and understanding of this chronic respiratory disease.
- 6) The assessment and management of Michael's chronic asthma condition was not in accordance with the BTS/SIGN Guidelines. In particular: lung function (peak expiratory flow/ PEF or spirometry) was not always measured when indicated; his medication was not optimised despite poor control; current asthma control was not always assessed using one of the tests recommended; Michael's frequency of use of relievers was never recorded; inhaler technique checking was not recorded; and there was no evidence in the GP or hospital records that a Personal Asthma Action Plan (PAAP) detailing the use of medication, recognising danger and how and when to call for help, had been issues to Michael.
- 7) Two further areas of concern presented, inter related but independently significant and critical in this matter:
 - A) Michael's mother readily presented her child for care in and out of hours to primary care and secondary care, but there was a lack of effective communication between these services, either at the time of referral or after consultation and

	<p>treatment.</p> <p>B) Evidence was also received of the failure to refer this child to a tertiary respiratory service which may have resulted in a different approach to his treatment which may have prevented his death, by:</p> <ul style="list-style-type: none"> i) The general practitioners who failed to recognise the severity of his condition and that referral to a tertiary unit could have been considered. ii) The A&E and inpatient service at the local hospital. <p>8) Michael was never formally referred to a tertiary respiratory service.</p> <p>9) The National Review of Asthma Death (NRAD) 2011-2014 was published in a report entitled 'Why Asthma Kills' on the 6th May 2014. The Review's evidence based conclusions and recommendations exemplify and underline the same missed opportunities and poor practice which led to Michael's death.</p> <p>10) Following the NRAD recommendations published in May 2014, and widely publicised in local and national media, and GP Press, Michael's high risk status was not recognised which should have prompted a referral to a difficult or severe asthma service run by a paediatric respiratory specialist.</p> <p>11) The conclusions of the Review would not of themselves have impacted on the events leading to Michael's death but in the context of seeking to avoid future deaths, the Review and the evidence of Michael's Inquest identify a need by both national and local agencies to revisit the recommendations of the Review, the formal substance of training identified as appropriate for the care and treatment of Asthma, the nature of that disease and the strategies essential for the long term management, care and prevention of uncontrolled re-occurring attacks.</p> <p>12) It is right to acknowledge that the local Trust in this matter have responded to the criticism directed towards them and sought to identify better practices for the future, their experience needs to be shared by and with other medical care professionals on a continuing bases, and their resolve to do so, evidence of their commitment that lessons have been learned.</p> <p>13) There are undoubtedly resource issues implicated in this matter but a demonstration of resolve and an effective lead given by the Department of Health and those involved in the provision of Health Service guidance and education nationally would demonstrate a universal resolve to standardise the care of chronic asthma patients and to make paediatric asthma death a "never event".</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>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.</p> <p>I am of the firm opinion that if the recommendations of the National Review for Asthma Deaths, published in 2014, had been locally disseminated and implemented would have prevented the death of MU.</p> <p>Since the death of MU there have been at least a further seven child deaths in London due to asthma and certainly many more throughout the NHS England.</p>

I am aware of the Regulation 28 that was issued following the inquest of Tamara Mills (died April 2014) issued in 2015 which highlighted the concerns of Her Majesty's Senior Coroner Terrance Carney for Gateshead & South Tyneside.

There has been a body of work published by NHS England over the last seven years, which pertain to the body standards and recommendations to improve the care of children and adults with asthma and prevent deaths. I have also seen the response to the regulation.

Fifteen months on, I would like to enquire what is the process and timelines by which the following recommendations from NRAD 2014, which were identified in the Regulation 28 will be implemented across NHS England.

7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 19th May 2017. 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]

[REDACTED]
Consultant in Respiratory & General Paediatrics
Cambridge University Hospitals
(email)

[REDACTED]
Kenton Bridge Medical Centre
155-175 Kenton Road
Kenton
HA3 0YX

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.

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22nd March 2017

A handwritten signature in black ink, appearing to read 'S.A. Radcliffe', written in a cursive style.

**Dr Shirley A Radcliffe
HM Assistant Coroner,
Inner West London,
Westminster Coroner's Court,
65, Horseferry Road,
London.
SW1P 2ED.**