ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive Cardiff & Vale University Health Board,** [redacted]
1	**CORONER** I am Graeme Hughes, Acting Senior Coroner, for the coroner area of South Wales Central.
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 28th March 2019 I commenced an investigation into the death of Lewys Ryan Aidan CRAWFORD. The investigation concluded at the end of the inquest 14th February 2020. The conclusion of the inquest was Natural causes contributed to by neglect - gross failure up to and including 11:30pm on 21/03/2019. Cause of Death recorded as:- 1a. Meningococcal Septicaemia (Group B)
4	**CIRCUMSTANCES OF THE DEATH** These were recorded as :- It is likely Lewys was in early stages of Meningococcal disease when he was admitted to A&E at University Hospital of Wales, Cardiff on 21/03/2019 at 08:15pm. There were multiple opportunities missed before 11:30pm to identify Lewys as having one or more high risk factors for Sepsis. There was a failure to treat Lewys with antibiotics before 11:30pm and this significantly contributed to Lewys' death on 22/03/2019 by which time he had been transferred to the Paediatric Critical Care Unit. The Inquest focused upon numerous issues. However, at its core was the appropriateness, timeliness, and causative significance of the care provided to Lewys following his presentation to A & E. Particularly in the early stages of his treatment between triage and around 11.30pm on 21.3.19
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) A potential deficiency in the knowledge and understanding of A & E Consultants covering in the paediatric A & E Department (whilst there is no on site consultant in paediatric emergency medicine) in the identification/diagnosis of sepsis in babies and very young children. Whilst it is appreciated that the quest to recruit further consultants in paediatric emergency medicine to provide more comprehensive cover in the Department continues, until such time as a sufficient complement is in place, and A & E Consultants provide some of the cover, the Health Board must ensure that those that do, are urgently and adequately trained to a competent standard to deliver the care required. It cannot be simply left to the individual consultants to determine their own requirements in this regard. As their employers, the Health Board, has an overarching obligation to ensure that competent staff are employed and to maintain high professional standards. (2) There needs to be a greater understanding of, and reference to the NICE Sepsis risk stratification tool: children aged under 5 years in hospital by Clinicians and Nurses in both the A & E & Paediatric depts. Whilst it is appreciated that the finalisation of a bespoke sepsis tool, *based upon* the UK Sepsis Trust's Tools and Pathways is awaited, until such time as its adopted, the Health Board needs to address apparent lapses in the understanding of what is required upon diagnosis of a potentially septic baby/child, particularly in the period between triage and admission to the ward. Specifically, the importance of stabilising the patient prior to transfer by completing a full septic screen. Furthermore, the Inquest highlighted gaps in the understanding and knowledge of agency nurses as to the septic screen and the steps to be followed. The Health Board needs a clear policy (and to ensure this is implemented & followed) to ensure that agency nurses are up to date with their training and understanding in this area of practice. (3) Guidance and instruction to both clinicians and nurses as to the appropriate use (and recording) of terminology should be considered in suspected sepsis patients. There was a degree of confusion in both the A & E & Paediatric Departments caused by the interchangeable use of *sepsis and bacterial infection* as to what treatment should be initiated/progressed depending on which description was used. If sepsis is suspected, that clear and continuing reference ought to be maintained, if, and until it is superseded by an alternative diagnosis. (4) In suspected sepsis patients, particularly babies, guidance and instruction needs to be emphasised to clinicians & nurses as to alternative methods of administration of antibiotics. Evidence at Inquest demonstrated that there were failures to consider alternatives to cannulation for IV antibiotics, such as intra-muscularly or intra-osseously.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 26th April 2020. 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 family who may find it useful or of interest. Health inspectorate Wales, Welsh Government [redacted] Medical Director

	of Cardiff and Vale Health Board. 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	28th February 2020 **SIGNED:**  Graeme Hughes, Acting Senior Coroner for **South Wales Central**