Derek Winter DL
Senior Coroner for the City of Sunderland

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Secretary of State for Health and Social Care**
1	**CORONER** I am Derek Winter DL, Senior Coroner for the City of Sunderland
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** On 28th November 2018 I commenced an Investigation into the death of Sheldon Gary Farnell, who was born on 28th September 2014 and died on 26th November 2018, aged 4 years. The Investigation concluded at the end of the 5-day Jury Inquest on 19th March 2021. The conclusion of the Inquest was Natural Causes, the medical cause of death being: - 1a Overwhelming Sepsis (Group A Streptococcus Pyogenes) 1b Acute Left Otitis Media
4	**CIRCUMSTANCES OF THE DEATH** The Jury recorded, as follows: - Sheldon Gary Farnell died at Sunderland Royal Hospital on Monday 26th November 2018 at 08:42hours. Sheldon had presented at Paediatric Accident and Emergency Department on Friday night as very unwell and was admitted. Sheldon had a number of contacts with medical staff and nursing staff during his admission, together with a range of tests and observations. The clinical team believed he was improving. Sheldon was discharged from the hospital before antibiotics for adverse blood test results (known about shortly after his discharge) could be given, and he was not able to be recalled to the hospital for that purpose.
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.

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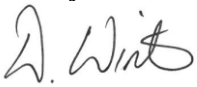
	The **MATTERS OF CONCERN** are as follows: – 1. Guidance for the recognition of sepsis may be in need of expedited revision with protocols reflecting up to date NICE guidelines. 2. Sepsis training should be mandatory and delivered by doctors with relevant experience of current research and guidance. 3. The messaging about the timely and prompt prescribing of antibiotic medication is in need of a review, as the Inquest highlighted issues of a possible overly cautious approach in their use, when there was no impediment to such use, and they may have saved Sheldon's life. 4. Contact details for families need to be positively given (not confirmed) at the time of admission and discharge within a hospital setting.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 21st May 2021. 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: - • Family • South Tyneside and Sunderland NHS Foundation Trust and their Counsel and Solicitors • Risk and Inquest Manager, South Tyneside and Sunderland NHS Foundation Trust • Dr [redacted], Consultant Paediatrician and Clinical Director of Child Health and his Counsel and Solicitors • Dr [redacted], Senior Paediatric Trainee and her Counsel and Solicitors • Care Quality Commission (CQC) 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 this 25th day of March 2021 Signature  Senior Coroner for the City of Sunderland