REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Chief Executive, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust** **2. Care Quality Commission**
1	**CORONER** I am Dr Elizabeth Didcock, Assistant Coroner, for the coroner area of Nottinghamshire
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 the 28th April 2020, I commenced an investigation into the death of Jacub Owczarek, aged eleven months. The investigation concluded at the end of the inquest on 30th April 2021. The conclusion of the inquest was a narrative as follows: Jacob Owczarek presented to Bassetlaw Hospital Nottinghamshire, at the age of six months, very unwell. He had pyelonephritis, a serious kidney infection. This was treated, but he did not continue on an antibiotic to reduce the risk of further urinary infection after discharge, as was necessary, as the family did not understand this was required. Follow up investigations to look for underlying abnormalities of the renal tract were performed. These scans showed obstruction of both ureters, the tubes that drain urine from both kidneys down to the bladder. The scan results were not reviewed in life, either at the time the scans were performed, nor when Jacob presented again at the age of ten months with a further kidney infection. Jacob died at age eleven months from acute pyelonephritis. He also had evidence of chronic kidney scarring and infection, with severe urinary obstruction at the time of his death. Had the scans been reviewed in life it is likely on a balance of probability that he would have had treatment to relieve the obstructions, and would not have died. His death was contributed to by Neglect.
4	**CIRCUMSTANCES OF THE DEATH** Jacob died from an acute kidney infection (pyelonephritis), a treatable condition. He had presented on two previous occasions unwell with sepsis from the urinary tract. The seriousness of the infection on the second presentation, was not recognised, and he was allowed home. The investigations arranged to look for underlying structural abnormalities of the renal tract were not reviewed in life, and therefore Jacob was never referred for surgical treatment to relieve his obstructed renal tract. There were systemic failings in his care, that remain in my view despite a Serious Incident Investigation undertaken, and action plan completed, by the Trust.

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. Continuing low compliance with the Paediatric sepsis screening tool 2. Lack of Named/Responsible Consultant review prior to a child's discharge 3. No alert/review system for ICE results yet in place for all the Paediatric team 4. No current system for recording a discussion about a child, in the Radiology meetings (where important investigations are planned) 5. The risk of continuing Login issues when Locum doctors are working at the Trust
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 the 29th September 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. I ask that the CQC undertake a visit to the Trust after 29.9.21 to review the compliance with the Paediatric sepsis screening tool, a serious safety issue that has been highlighted by myself and the Doncaster Coroner repeatedly in PFD reports over the last 5 years.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: [redacted], Jacobs' parents [redacted], GP, Newgate Medical Group 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 July 2021** **Dr E A Didcock**