Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Chief Executive NHS England** **2 Chief Executive Health Education England** **3 Chief Executive NHS Digital** **4 Chief Executive SECAMB**
1	**CORONER** I am Karen Henderson, assistant coroner, for the coroner area of West Sussex Coroners Service
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 5th July 2020 I commenced an investigation into the death of Hannah Elizabeth ROYLE aged 16. The investigation concluded at the end of the inquest on 29 July 2021. The conclusion of the Inquest was that the medical cause of death was: 1a. Hypoxic brain injury 1b. OOH cardiac arrest 1c. acute gastric volvulus 2. Global developmental delay – Autistic – non verbal, renal atrophy (single functioning kidney) I recorded a conclusion of natural causes contributed to by neglect
4	**CIRCUMSTANCES OF THE DEATH** Hannah Elizabeth ROYLE was a 16 year old girl with a life-long severe learning disability. She was non-verbal and required care for all of her activities of daily living. She lived with her parents and with their support she attended school and had a full and active life within the limitations of her disabilities. Hannah had been generally fit and well until the 19th and then into 20th June 2020 when she first had some diarrhoea and then began vomiting. Her father phoned 111 service at 15.15 hours on 20th June 2020 for advice as he did not his wish to overburden the 999 service given the impact Covid pandemic was having on the emergency services. The advice received was a primary care physician would contact them within 12 hours. Hannah's mother contaced 111 service again at or around 18.00 hours. She said Hannah's condition had deteriorated in that she was continuing to retch, unable to tolerate any fluids, her abdomen was 'tight as a drum' and she was concerned Hannah had a 'blockage'. The 111 call handler went through the algorithm for abdominal pain. On obtaining 3 'not

	sure' answers he discussed this case with the on duty 'clinical advisor' who advised the call handler to ask further questions. After doing so, the call handler asked her mother to take Hannah to the emergency department at East Surrey Hospital. On the way to East Surrey hospital Hannah had a cardiorespiratory arrest. Her mother carried out cardiopulmonary resuscitation in their car until their arrival at the hospital when she was immediately intubated and ventilated and was successfully resuscitated and stabilised. Investigations at East Surrey Hospital diagnosed Hannah with a massive gastric volvulus. A nasogastric tube was inserted and drained 3.5 litres of gastric fluid. Shortly thereafter she was transferred to the Royal Surrey County Hospital, Guildford and underwent a successful laparotomy to release and correct the volvulus in the early hours of 21st June 2020. On 28th June 2020 Hannah was transferred back to East Surrey hospital having shown no signs of neurological recovery. A brain MRI scan confirmed Hannah had sustained an irreversible hypoxic brain injury at the time of the cardiorespiratory arrest. This was incompatible with life and Hannah was declared brainstem dead at 10.30 hours on 1st July 2020 at East Surrey Hospital, Redhill. Her parents kindly consented to organ donation. On the evidence I heard I am satisifed the 111 service failed to provide the appropriate triage for Hannah on the information provided to them by her parents. This resulted in a cardio-respiratory arrest arising from an avoidable delay in being adequately resuscitated either by prompt attendance of the emergency services or through earlier admission into hospital.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could 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. Both calls to the 111 service were significantly non-compliant; the call handlers did not correctly complete the algorithm, they did not take into consideration Hannah's disabilities and inability to verbalise, they failed to recognise Hannah as a complex case requiring transfer to a more senior member of the 111 service despite Hannah's parents providing sufficient information for that to be the case. 2. The 111 service does not have a sufficiently robust system to manage members of the public with underlying disabilities in that no accommodation is given for it in the completion of the algorithm. 3. The skill and expertise of the 'clinical advisor' was wholly inadequate for her position as she had no contemporaneous or relevant experience in working in an emergency department as a nurse. She was also insufficiently robust in her assessment and understanding of Hannah's condition when the call handler contacted her for advice. 4. Members of the public who contact the 111 are ill-informed with a real risk they are being misled over the role and capability of the 111 service. There is little clarity or understanding by the public that it is based on following and completing an algorithm by individuals who have no need for any qualification in health care and who will only receive a short training programme after they are employed. Hannah's parents indicated that if they knew this, they would have opted to ring 999 and the outcome would have been different. 5. The 111 service is not a 'diagnostic' service yet the 'call handlers' have been renamed 'health advisors'. This is misleading to the public as it iimplies

	professionalism which is untrue given their underlying skills and unsubstantiated given it is their role to complete an algorithm. 6. The NHS pathway for 'Abdominal Pain' is insufficiently robust or sufficiently discriminatory to effectively deal with the myriad of potential symptoms associated with this complaint.
6	**ACTION SHOULD BE TAKEN** 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.
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 December 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 1. [redacted] and to the Local Safeguarding Board (where the deceased was 18). I have also sent it to Dr [redacted] who may find it useful or of interest and to the Child Death Overview Panel (CDOP). I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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: 04/10/2021** **Karen HENDERSON** **Assistant Coroner for** **West Sussex Coroners Service**