	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Mr Garret Emmerson, Chief Executive Officer, London Ambulance Service, 220 Waterloo Road, London SE1 8SD 2. Ms Kim Wright, Chief Executive London Borough of Lewisham, Laurence House, 1 Catford Road, London SE6 4RV 3. [redacted] Sydenham Green Group General Practice, Sydenham Green Health Centre, 26 Holmshaw Close, London SE26 4TH 4. Mr Ben Travis, Chief Executive, Lewisham & Greenwich NHS Trust, Queen Elizabeth Hospital, Stadium Road, London, SE18 4QH
1	**CORONER** I am Andrew Harris, Senior Coroner, London Inner South jurisdiction
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INQUEST** I opened an inquest into the death of Master Omarian Brooks, who died aged 11 years on 28th May 2017 (01552-2017). After a number of corporate investigations, including a Serious Case Review, concluded on 13th January 2020, reserved judgment being delivered on 23rd January. Delay in processing this report was occasioned by the Senior Coroner being on sick leave for a month and the priorities of the pandemic. The medical cause of death was: 1a Sepsis 1b Pneumonia II Complex neuro-disability. The narrative conclusion was natural causes contributed to by a failure to adopt a patient specific care protocol covering appropriate health and emergency care in an acute deterioration.
4	**CIRCUMSTANCES OF THE DEATH** This severely disabled boy was given antibiotics by his parents on 22nd May, but it appeared that the GP was unaware of this and his continued deterioration, for which there was no protocol for management, although there was a discussion between the duty doctor and parents on 24th about the dose of Clonidine (not an antibiotic). On 27th an ambulance was called and he died *en route* to hospital, without having had a GP visit. There was no agreement between the general practice and the Serious Case Review Report as to whether there was over-reliance on the parents to gauge the seriousness of his medical conditions. The family had asked for the London Ambulance Service to arrange a patient specific protocol in the past, which was not in place; a Child In Need Plan was never completed by the Local Authority, in part due to a meeting with relevant professionals not being held.
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows. – 1. The Record concludes that had the GP been informed of the boy's deterioration either 4 days before the antibiotic was started or soon after, he would have been admitted to hospital with a real prospect of the infection being successfully treated.

	2. There was also a distressing dispute between the ambulance crew and parents as to which hospital Omarian should be taken, in the event he was not taken to the nearest hospital at the insistence of his parents (although in this instance the delay was not found to have contributed to the death).
6	**ACTION SHOULD BE TAKEN** It is not for the court to determine whether earlier admission to hospital of potentially septic disabled children is achieved by a Patient Specific Protocol or Child in Need Plan or by way of mandating informing the general practice that antibiotics had been started, or a combination of these or other forms of multi-disciplinary care. Accordingly these agencies and the local hospital are the subject of the report as in my opinion their joint action should be taken to prevent future deaths. It is not clear that the steps taken by the general practice for the duty doctor to inform colleagues of a consultation, nor the action plan by the Borough implementing the recommendations of the SCR, which refers to standby antibiotic usage (and not communications with the GP), and does not specifically involve the London Ambulance Service can be relied upon to prevent such a death recurring. Some information was submitted after conclusion of the inquest by L&G NHS Trust, which had not been admitted as evidence and may usefully be part of the response to the report. I believe that these organizations would wish to learn of the evidence given in the inquest about the circumstances of this death and can mitigate or prevent future deaths by articulating their joint 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 Friday 24th July 2020. I, the coroner, may extend the period. If you require any further information or assistance about the case, please contact the case officer, [redacted]
8	**COPIES and PUBLICATION** I have sent a copy of my report to the following Interested Persons: [redacted] I am also sending this report to the following, who have an interest and may be in a position to offer advice on mitigating such tragedies: Evelina Children's Department, Guys and St Thomas' Hospital NHS Foundation Trust and Royal College of Paediatrics and Child Health. 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	**[DATE]** **[SIGNED BY CORONER]** **29th May 2020** **Andrew Harris, Senior Coroner**