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King's Bench Walk

Isaac Hogarth helps secure rider of neglect for bereaved family in paediatric sepsis hospital inquest

Isaac Hogarth of 12 King's Bench Walk, instructed by Rosie Nelson and Emily Palmer of Penningtons Manches, appeared on behalf of the parents of AJ, a 5-year-old boy who died from sepsis, following treatment received at Hillingdon Hospital on 22 December 2015. Based on his initial presentation, AJ was treated for croup. However, when he failed to respond positively to that treatment, he was not properly reassessed. There was therefore a significant delay in IV antibiotics being prescribed. HM Coroner gave a narrative conclusion with a rider of neglect, finding that AJ's death was avoidable and that there were gross failings in the care he received.

On 21 December 2015, AJ's mother took him to see his GP with a temperature, a cough, and a rash over his body. His chest seemed clear on examination, and his mother was told to ensure that her son rested and drank plenty of fluids. AJ was prescribed cough syrup, Cetirizine for his rash, and Dioralyte to rehydrate him.

During the night, AJ began to suffer from diarrhoea. His cough became wheezy, and he continued to have a high temperature. By the early hours of the morning, his parents decided to take him to the accident and emergency department of Hillingdon Hospital, and they arrived just before 4am. He was admitted and a medical history was taken. AJ was initially treated for croup (a viral respiratory infection) and was given oral steroids and provided with an oxygen mask. When his cough did not improve, he was transferred to the resuscitation area of the accident and emergency department at 4.15am.

AJ became agitated. His heart rate and breathing rate were abnormally high, and his oxygen saturation levels were low. Despite his deteriorating condition, which was not improving with treatment for croup, alternative diagnoses were not considered by Hillingdon Hospital doctors.

At approximately 12.15pm, doctors tried to cannulate to take bloods and administer IV antibiotics. Their attempts were unsuccessful and AJ was getting increasingly agitated so it was decided to try again later. A further attempt to cannulate was made at 2.30pm, and doctors noticed a non-blanching rash under A J's armpits. At this point, sepsis was suspected, and blood tests and a chest x-ray were ordered. The x-ray showed right lower lobe consolidation, and blood results demonstrated metabolic acidosis and a high lactate level, indicative of sepsis. IV antibiotics were administered and an assessment of toxic shock syndrome was made after almost 12 hours in A&E.

The hospital anaesthetics team was called, and the Children's Acute Transport Service (CATS) from Great Ormond Street Hospital were contacted at 4pm. On arrival at 6pm, they tried to stabilize AJ, and a decision was made to transport him to Great Ormond Street Hospital to use Extracorporeal Membrane Oxygenation (ECMO) equipment which was felt to be his best chance of survival.

At 8pm, AJ was transferred by ambulance to Great Ormond Street Hospital. He suffered cardiac arrest during transfer, and CPR was commenced. Attempts to resuscitate continued on arrival at the hospital, but A J very sadly passed away soon after 9pm. A post-mortem carried out showed the cause of death to be bacterial pneumonia with sepsis.

As part of his conclusion, the Coroner, found as follows:

1. *There were identifiable failings in provision of care to [AJ], notably a failure to recognize the basic fact that he was very seriously ill and over time developing septic shock and needed aggressive and vigorous treatment. There was a failure to consider alternate diagnoses in a timely fashion, to start intravenous antibiotics by 0800 am on the 22nd December 2015 and a failure to secure anaesthetic assistance by 1330.*

2. *That these failings relate to basic care.*

3. *That these failings were gross.*

4. *That [AJ's] clinical state clearly required this basic level of care*

5. *That there was a clear and direct causal connection between the failure to recognize how ill [AJ] was and the consequent failure to institute appropriate and vigorous treatment and this led to his death.*

My conclusion is a narrative one.

[AJ] was 5 years old when he died from sepsis, lung abscess and bacterial pneumonia on the 22nd December 2015 at Great Ormond Street Hospital. His death was avoidable and was contributed to in part by neglect.

Isaac was instructed by Rosie Nelson and Emily Palmer of Penningtons Manches.