Summary: Regulation 28 Report to Prevent Future death for Katie Wilkins (died 26.5.2022)

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This is a brief summary of the regulation 28 coroners report into the death of *Katie Wilkins* from which you can review the coroner recommendations to health care and consider whether there are changes you could implement in your local NHS trust to address them

Clinical summary

14-year-old girl who was previously well

Events around death

- Recurrent presentation (6) of labial abscess with increasing pain, fever and tachycardia.
- Surgical management. No blood tests done.
- Katie collapsed at home: Acute Promyelocytic Leukaemia with an associated coagulopathy
- Fibrinogen concentrate needed but not given.
- Intracerebral haemorrhage leading to brain stem death

Coroner's Recommendations

- Oncology consultants lead care for APML patients at that trust but care should be co-led with haematology in view of coagulopathy risks to prevent future deaths
- There is a national shortage of haematologists that needs to be addressed

Key Themes

- Repeat presentations with missed opportunity for investigation/intervention
- Timely involvement of the correct specialist is needed, and this is affected by workforce planning
- Medication/treatment not given in a timely manner

Local Improvement suggestions from this report:

- Review clarity handover of treatment plans between members of the clinical team
- Review local referral pathway to tertiary specialities for new presentations of APML in your trust
- Implementation or review of paediatric early warning scoring systems
- Consider mandated senior review of rapid repeat presentations to emergency care

For full information visit:
www.judiciary.uk/prevention-of-future-death-reports/katie-wilkins-prevention-of-future-deaths-report/
or follow the QR code