Bridgewater Community Healthcare NHS
NHS Foundation Trust

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23 January 2015

STRICTLY PRIVATE AND CONFIDENTIAL

Mr J Pollard
HM Senior Coroner
Coroner's Office
Town Hall
Stockport Borough Council
SK13XE

Dear Mr Pollard

Mikey James Hornby (Deceased)
Response to Regulation 28: Report to Prevent Future Deaths to Bridgewater Community Healthcare NHS Foundation Trust

Please find below the response of Bridgewater Community Healthcare NHS Foundation Trust following the inquest into the death of Mikey James Hornby and the Regulation 28 Report which you issued on 15 December 2014.

Your concerns were set out in the Regulation 28 Report as follows:

"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. On the first attendance at the Out of Hours Service, the attending staff having seen the infected umbilical cord, did not immediately send Mikey to the Hospital (as would have been the correct procedure according to the Consultant Lead Paediatrician who gave evidence to me).

2. On the second attendance the doctor failed to appreciate the seriousness of the situation and at 10.45 at night sent the child home with a prescription for analgesia (which could not be filled until the following day in any event). The Consultant Paediatrician gave evidence to me "that there was a very high probability that he would have survived" had he been sent to the hospital at this time as he could and would have been administered an intra-venous anti-biotic.

3. If there is any realistic possibility of the condition being meningitis, the child should have been immediately admitted to the hospital.

4. The GP covering the surgery that night indicated that they do not have the facility to take a simple blood test. If this is the case, then they should utilise the adjacent facilities at the Emergency Department of the hospital."

You also indicated that in your opinion, "there is a very clear training need identified here, in relation to the appreciation of this type of occurrence with very young children".

Response of Bridgewater Community Healthcare NHS Foundation Trust

1. Procedures for referral from out of hours to Hospital

In 2013, the Trust implemented national NICE guidance dated May 2013 entitled "Feverish illness in children: Assessment and initial management in children younger than 5 years" which is based on validated algorithms. A copy of a link to the NICE guidance is enclosed, for your ease of reference: http://www.nice.org.uk/guidance/cg160/chapter/recommendations.

The Trust is fully compliant with this guideline. The Trust uses the Paediatric Early Warning Score (PEWS) system in the GP Out of Hours service as a way of ensuring that the steps recommended in the NICE guidance are considered (please see attachment one). Although the score sheet was not available during [redacted] examination of Baby Mikey, running the score from the clinical data of the consultation the score is 0-2 which did not indicate further action was required.

If either [redacted] or [redacted] had decided that further action was required, there is a well-defined pathway for referral of patients to the Paediatricians at the hospital.

The Trust reviewed the care provided to baby Mikey through its Root Cause Analysis process, which concluded in May 2014. This included review by peers within the organisation. The root cause analysis investigation concluded that [redacted] complied with NICE guidance in his assessment of baby Mikey but that more attention could have been given to his feeding pattern and the possibility of dehydration. Appropriate safety netting advice was also provided.

The Root Cause Analysis undertaken by the Trust did identify areas of learning, namely:

1. Ensuring a full history is taken from the parents when assessing babies, in particular in relation feeding patterns.

2. Ensuring that documentation (the PEWS sheet) is available to practitioners on the electronic system.

3. Ensuring that information can be shared between organisations easily and quickly.

2. Blood tests within the out of hours service

In common with any GP practice, the GP Out of Hours service does not routinely take blood from children, including urgent circumstances, as we would not receive a report back in a timely enough manner to influence our decision making. If a practitioner felt that a blood test was likely to be important to the clinical decision making process, there is a clear referral protocol to the Paediatric department. A&E is not a referral route that we would use as there are pathways for an emergency referral to be made directly to the Paediatricians rather than patients waiting unnecessarily in A&E. At the time [redacted] saw the patient, a blood test was not deemed necessary, as evidenced through the NICE guidelines but if it had have been, an emergency referral to the Paediatricians would have been made.

Although it is unlikely to have affected the outcome in this tragic case, we have internally reflected that the Out of Hours drug cupboard stock of paracetamol should have been used rather than issuing a prescription at that time of night, particularly in the light of the age of the baby. This has been communicated to practitioners within the service, and we are sorry that it did not occur in this case.

3. Training

All new staff undertake both a corporate and a local induction to ensure they are aware of the policies and procedures in place as they take up post. Any new or reviewed Policies, Procedures and Guidelines are cascaded to clinical and medical staff with advice on the areas that need to be supported in practice via a bulletin to staff (examples included – please see attachments two and three). Significant guidance such as the new NICE advice on feverish illness in children is implemented into practice with templates to support assessment and management of care.

Ongoing checks on the quality of the services we provide are made via quarterly clinical audit reviews, where a sample of clinical and medical records from each practitioner are reviewed by the clinical director enabling best practice to be recognised and shared with colleagues. Where best practice is not followed a period of supervision and formal support with competency improvement action plans is implemented.

Annual appraisals take place with all staff. Learning from incidents in service allows GPs to review their training needs so that alongside maintaining their annual Mandatory and Statutory Training, particular development needs can be met. For GPs in the Out of Hours Service, their Bridgewater-specific training will often run alongside the continuing professional development they undertake as part of their practice. In [redacted] case, he has undertaken training on management of the severely ill child to support his general practice role.

You may be aware that the Warrington Safeguarding Children Board is undertaking a local review of the case and I will share a copy of your Regulation 28 report with the reviewers. If you would wish to be kept informed of the outcome of the review, please do let me know.

I hope that this response provides assurance that the policies and practices implemented by Bridgewater Community Healthcare NHS Foundation Trust are in line with national guidelines issued by NICE. The Trust reacted very swiftly to the extremely sad news of Mikey's death. We would like to extend our sincere condolences to his family and have met with them as part of the Trust's complaints process. We would of course be happy to meet again if the family would find that helpful.

Please do not hesitate to contact me if you require any further information in relation to our response.

Yours sincerely

[redacted]

Dr Kate Fallon
Chief Executive

Enc

Cc: [redacted] (parents of Mikey)

[redacted] (Consultant Paediatrician)

Mr Nicholas Rheinberg (HM Senior Coroner for Cheshire)

[redacted] – Inspector, Hospital Directorate
Care Quality Commission

Bridgewater
Healthcare at the heart
of your community

Bridgewater Community Healthcare NHS
NHS Trust

Warrington OOH/Urgent Care GP unit Bulletin

August 2014

Hi all,

Hope you have enjoyed or are on a break.

Continued thank you for all the hard work that you put in to keeping the service running.

1. Rotas:

   Please can everybody check the rota for PCUCU and OOH when they arrive, they normally come out 4 weeks before the start of the rota. There are still occasions when people have been down for a shift incorrectly and not realised thus effecting the service provision or have not turned up as they did not know they were working.

   Can I ask EVERYONE (even if you think you are not working) to THOROUGHLY check the rotas and inform the office IMMEDIATELY of any errors, this allows for correct staffing and cover to be arranged.

2. Car Parking:

   Warrington hospital has changed the car parking system.
   Further information will be forthcoming once the hospital works out what it is doing!

3. I am pleased to report that we once again were **97%** compliant in our record keeping.

4. CQC: CQC will at some point be visiting and reviewing the OOH services you should have all received an email from Sharon highlighting the key areas that will be assessed. You should have seen that the majority of these are already compliant.

5. Streaming: There have been occasions when a shift cannot be covered (see point 1) or due to illness, this has meant that the services have had to merge. AED have always been informed of this and that streaming will continue as normal.
   It is essential that we keep the service running smoothly as much as possible.

6. An incident occurred back in April involving the OOH service and a young child, the child was seen by OOH the night before he sadly passed away. The records and the reports by those involved have demonstrated an excellent level of care delivered by the OOH service; this has been possible to review due to the high quality note keeping (as highlighted in point 3)

   The case is now under the remit of the coroner's court.

   The post mortem showed an E.Coli infection via the umbilicus

   A letter has been written by Paediatrics which I have been asked to disseminate to you all:

IDENTIFICATION OF UMBILICAL INFECTION (OMPHALITIS)

Insert Date: 10th August 2014

Alerts are circulated to raise awareness of risks that may lead to errors and reduce the risk to patients, staff, visitors and contractors in the future. They are produced following a review of systems, procedures, incidents or following information provided by staff within the Trust or by an External Agency.

Notification to all staff involved in care of children

Situation: The incidence rate for umbilical infection is between 2–7/1000 live births. In developing countries, the incidence of omphalitis varies from 2 to 7%. Overall mortality rate is 7-15%. With complications, as meningitis, necrotising fascitis and myonecrosis, the mortality rate is 38-87%. Risk factors for poor prognosis include male sex, prematurity or being small for gestational age, and septic delivery (including unplanned home delivery).

Background: An 11 days old male infant who died suddenly and unexpectedly at home showed disseminated E Coli infection with meningitis on autopsy The family has had visits from the community midwifery team during the first week of his life and the infant was thought to be healthy. The infant was treated for umbilical infection with topical Fucidin on day 6 of life. One day before his death, the infant was having fever and respiratory difficulty and prescribed paracetamol. The infant was feeding poorly and had lost around 20% body weight (from birth weight).

Assessment and Risk:
In most healthy babies the umbilical stump drops off between 7-10 days after birth. The plastic clamp is taken off the tie after a few days, when the stump has dried and sealed. In some areas, the midwife will leave the tie or clamp on until the stump has fallen off. It's normal for the stump to look a bit mucky as it's healing, or to have some moisture at the base. This doesn't mean that it's infected
The stump itself will then shrivel up, turn black, and drop off. There is a small wound that will heal and becomes the belly button.

Omphalitis
Umbilical infection is caused by both gram positive, gram negative and sometimes by anaerobic bacteria. It is important to ensure that health professionals identify infants with umbilical infection and regard it as a medical emergency for the infant's hospital transfer and treatment with intravenous antibiotics.

Symptoms that may suggest presence of infection include poor feeding, vomiting, irritability, respiratory difficulties or skin rash. Fever is present in less than 33% of neonates with sepsis and over 66% infants present with normal or low core temperature.

Features of uncomplicated omphalitis include:

- Purulent or malodorous discharge from the umbilical stump
- Periumbilical erythema or oedema
- Periumbilical tenderness
- Presence of petechae, vesicular or pustular lesions

It is recognised that the initial neonatal examination is usually normal and the symptoms and the signs of umbilical infection evolve following discharge from the hospital. All medical, nursing and community team should strongly consider the possibility of Omphalitis in all infants presenting with local or systemic signs of sepsis.

Recommended Action: Would all GP's, midwifery team, health visitors practice Managers and Heads of Children's Services in the hospital and the community kindly communicate to their staff as part of any communication briefings.

For further information or other queries, please contact: Dr Nisar Mir, Consultant Paediatrician Warrington & Halton Hospitals NHS Foundation Trust

7. An invite has been sent out regarding a Paediatric Symposium:

Dear Colleague

On behalf of the team, I am delighted to announce that the first Paediatric Symposium will be held on the 20th of November 2014 at Statham Lodge Hotel, Lymm from 9am to 13.00hours, followed by lunch.

All GPs, GP registrars, Nurse Practitioners and Practice nurses with an interest in Paediatrics are invited to attend.

There will be four educational workshops run by eminent speakers lasting about forty minutes each. All delegates can attend the four sessions.

Details of speakers, format and topics will be shared early September.

If you would like to attend, please email Jan Todd or myself:

Jan.Todd@warringtonccg.nhs.uk
ichatterjee@nhs.net

Regards

Ipsita

If there are any issues please email me neilfisher@nhs.net

Neil Fisher

Dr Neil Fisher

Clinical Director Urgent and Primary Care.

Bridgewater Community Healthcare NHS Trust.

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of your community

Bridgewater Community Healthcare NHS
NHS Trust

Warrington OOH/Urgent Care GP unit Bulletin

June 2014

Hi all,

1. The weekend of 21st/22nd June was very busy across the unscheduled system of primary and secondary care. The sister in charge of Paediatric AED sent her thanks to the staff on in PCUCU and OOH for their assistance in relieving the pressure that had developed in Paediatric AED.

2. No issues have arisen from the last staff meeting, this monthly meeting is between reception staff and management, it has been requested for clinical representation to be present and I attended on the 26th June, if any other clinicians would like to attend then let me know.

3. NWAS: below is an email bulletin from our colleagues, please take time to read this, it is for information purposes only. It especially applies to OOH , but may occur in PCUCU (although all attempts should be made to speak to patient's own surgery during open hours)

Thanks for taking the time to read this e-mail. I just wanted to mention an issue that occurred a few months ago, and to ensure that you and your staff are aware of NWAS procedures surrounding patient refusal to attend hospital. I appreciate that the incident is not a recent one, and that you may already have addressed it, however I wanted to highlight this problem in order to ensure that you and your staff were fully conversant with the method of triage and referral employed by our staff.

The incident involved one of your GPs. The issue arose as the NWAS ambulance crew were called to a patient who, they felt needed to attend hospital. Despite the crew's attempt to persuade the patient to travel to hospital with them, the patient refused. As the patient had full mental capacity, the ambulance crew were obliged to accept this, and attempted to make a referral to your service, in order to ensure that some kind of safety net was put in place for this patient. The Dr in OOH initially refused to accept this patient as they said that the referral was inappropriate. In a later phone call they did subsequently change their mind regarding this and did agree to accept the referral, although still saying that they thought it was inappropriate.

My concern regarding this incident is that they did not appear to understand the triage process undertaken by the ambulance crew and that the crew had attempted to take the patient to hospital. As the patient had full mental capacity and had refused hospital treatment, the patient fell into a category known colloquially as a "Red Refusal." This is a patient who has been assessed using our triage tool as high risk, but who has refused hospital treatment. For this patient group, NWAS staff have no option other than to refer to the GP services. My purpose in contacting you is to ensure that you and all your staff are familiar with the NWAS assessment and triage process. I am most happy to come and talk to your staff, in order to explain the NWAS assessment process, our triage tool along with its strengths and its limitations, and to highlight areas where ambulance staff may make referrals to your service that may, on the face of it, appear unsafe. Please do not hesitate to get in touch if you feel that I can be of any help to you in this matter.

Regards,

Jane Clayton
Advanced Paramedic

Cheshire and Mersey East
North West Ambulance Service
Tel: 07812 305620

4. Complaints:

There have been a couple of incidents recently involving OOH that demonstrate common themes. Listening to patients and Communication

Listening to patients:
Under GMC guidelines: Good Medical Practice:

Work in partnership with patients.

- Listen to, and respond to, their concerns and preferences.
- Give patients the information they want or need in a way they can understand.
- Respect patients' right to reach decisions with you about their treatment and care.
- Support patients in caring for themselves to improve and maintain their health.

Communication:
The Health and Social Care Information Centre (HSCIC) report into complaints 2012/13 showed:

In Hospital and Community settings:

46.2% of complaints were in respect of all clinical treatment
11.1% due to attitude of staff
10.5% due to communication
8% due to appointment delay

In Primary Care:

35.5% due to clinical issues
20.8% due to communication/attitude of staff
19.5% due to admin issues.

5. Note taking:

As I have stated in the last couple of weeks, it is the individual's responsibility to record their consultations.

Good Medical Practice states:

Record your work clearly, accurately and legibly:

- 19. Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make

records at the same time as the events you are recording or as soon as possible afterwards.

- 20. You must keep records that contain personal information about patients, colleagues or others securely, and in line with any data protection requirements.

- 21. Clinical records should include:
  - a. relevant clinical findings
  - b. the decisions made and actions agreed, and who is making the decisions and agreeing the actions
  - c. the information given to patients
  - d. any drugs prescribed or other investigation or treatment
  - e. who is making the record and when.

6. Distance from service: an email was sent out on 23rd June, in case you did not receive it:

Dear all

Further to a management meeting today regarding OOHs.

For the service to meet its local and national quality standards the service needs to demonstrate its ability to respond in an appropriate time.

This is especially important overnight:

If you are able to state that if called overnight you can be picked up and at the patient's house seeing the patient within 1 hour (wherever in Warrington the patient is) then you are able to cover the requirements, as set out in the OOHs quality standards.

If you cannot then do not request 1 -6 shifts, please.

Likewise it is your responsibility to write on TPP your consultation notes, this can either be real time via the Toughbook, or back at the base after, or (as long as the times are correctly entered, and the call handler has been informed) can be done first thing in the morning in your own surgery. It is not acceptable practice to hand write, dictate or email for the call handler to input.

The monthly bulletin is in the process of being written, if anyone has anything they want adding for general consensus or discussion then please let me know.

Thanks as always for the hard work.

7. Rotas:

Please can everybody check the rota for PCUCU and OOH when they arrive, they normally come out 4 weeks before the start of the rota. There have been a couple of occasions when people have been down for a shift incorrectly and not realised thus effecting the service provision.

Can I ask EVERYONE (even if you think you are not working) to THOROUGHLY check the rotas and inform the office IMMEDIATELY of any errors, this allows for correct staffing and cover to be arranged.

8. Car Parking:

   Warrington hospital is in the process of changing the car parking system, please ensure all registration numbers are correct, they are the OOH folder on the K drive. Further information will be forthcoming once the hospital works out what it is doing.

9. TPP dispositions:

   The office has asked me to pass on the following:

   If it is a 'speak to clinician' DX11 – this needs a clinician call back or re prioritisation – rather than being issued an appointment. The result has been an appointment offered has breached 2-3 hours out of time. If the appointment is unable to be given within the time then an exception should be recorded (usually by the receptionist) but may be the clinician/doctor

   If that makes no sense please speak to Dawn Richards (Operational manager for OOH) in the office.

10. Attached to the email is the latest Bridgewater Staff Briefing.

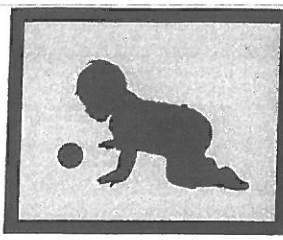
Thanks for all the hard work you put into the services, if there are any issues please email me neilfisher@nhs.net

Neil Fisher

Dr Neil Fisher

Clinical Director Urgent and Primary Care.

Bridgewater Community Healthcare NHS Trust.



PEWS Form
0-11 Months

Name
Date of Birth
NHS Number
Consultant
Ward

Frequency of obs																							
Every _____ hourly	Date	30/11																					
	Time	18:00																					
	Initial	SNM																					
Doctor/Nurse/Family concern?		✔																					

A

Respiratory Rate (Over 1 minute)	70	60	50	40	30	20	10
		●					

Respiratory Rate (number)	65

B

Respiratory Distress	Severe/Mod	✔
	Mild/None	

O_2 Saturation %	95
Receiving O_2 l/min	2

C

Heart Rate & Blood Pressure (*BP NOT used to calculate PEWS*)	200	190	180	170	160	150	140	130	120	110	100	90	80	70	60	50	40	30
	EXAMPLE							●					X			X		

Heart Rate (Number)	130

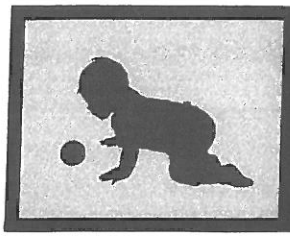
Conscious Level	Normal	
	Decreased	✔

Temperature °C	40	39	38	37	36	35
			●			

Temperature (Number)	38

0-2	3-4	5-6	5

PTO For Action — **Total PEWS** = Number of entries of shaded boxes — PTO For Action



PEWS Form
0-11 Months

Name
Date of Birth
NHS Number
Consultant
Ward

PEWS Escalation Aid

S **Situation:**
I am (name), a nurse on ward (X)
I am calling about (child X)
I am calling because I am concerned that…
(e.g. BP is low/high, pulse is XXX
temperature is XX, Early Warning Score is XX)

B **Background:**
Child (X) was admitted on (XX date) with
(e.g. respiratory infection)
They have had (X operation/procedure/investigation)
Child (X)'s condition has changed in the last (XX mins)
Their last set of obs were (XXX)
The child's normal condition is…
(e.g. alert/drowsy/confused, pain free)

A **Assessment:**
I think the problem is (XXX)
and I have…
(e.g. given O2 /analgesia, stopped the infusion)
OR
I am not sure what the problem is but child (X)
is deteriorating
OR
I don't know what's wrong but I am really worried

R **Recommendation:**
I need you to…
Come to see the child in the next (XX mins)
AND
Is there anything I need to do in the meantime?
(e.g. stop the fluid/repeat the obs)

Download SBAR prompt cards and pads at
www.institute.nhs.uk/SBAR

Remember: If you feel you need more help at any time, call for help – regardless of PEW Score

0 1	Continue monitoring
2	Nurse in charge MUST review
3	Nurse in charge & Doctor MUST review
4	Nurse in charge & Doctor MUST review & inform Consultant
5 6	Nurse in charge & Consultant MUST review

Record Call When PEWS 3 Or More				Record Time of Review, Who by & Plan		
Date	Time	PEWS	Print Name (nurse)	Time	Plan	Print Name
01/01/12	09:00	5	SN Morton	09:15	ED consultant called Anaesthetic review	Sister JACKS

NHS Institute for Innovation and Improvement

Download documents to use or edit at
www.institute.nhs.uk/PEWScharts