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. **Care Quality Commission**
2. **Public Health England**
3. **NHS England**
4. **Properly Interested Persons - The Family of Mr Tom Cribley (Deceased) and**
5. **Aintree University Hospital Trust Chief Executive**
6. **Clinical Director/lead of the Clinical Commissioning Group with responsibility for Commissioning care from Aintree**
7. **Senior Officers with responsibility for doctors and nurses training at the GMC and Nursing & Midwifery Council (Registrant bodies)**
8. **Chief Coroner for England & Wales**

1 CORONER

I am Julie Goulding; Assistant Coroner for the area of Liverpool & Wirral

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 22/08/2017 the Coroner commenced an investigation into the death of Tom Cribley. The investigation concluded at the end of the inquest on 18/09/2018. The conclusion of the inquest was;

Section 2 (Medical Cause of Death)

Ia Multi Organ Failure

Ib Meningococcal Sepsis

Section 4
Copied from the Record of Inquest

Conclusion of the Coroner (the Inquest was held with a Jury and engaged Article 2)

Natural causes
Contributed to by Neglect
A number of failings were also identified by the Jury-

Tom Cribley's death was caused by natural causes which was contributed to by neglect due to the following points:

- failure to record and document rash at triage
- failure to consider concerns of family throughout
- failure to provide consistent handovers throughout
- failure to complete pitstop process, resulting in delay of bloods being taken
- failure to monitor and record observations correctly throughout
- failure to document MEWS score and monitor MEWS
- failure to recognize and escalate deteriorating MEWS score
- failure to apply clinical judgment by observing Tom's physical presentation factoring in younger patients compensate better

- failure to consider differential diagnosis
- failure to assess and re-assess consistently throughout
- Delay in confirmation of blood results being provided to medical staff caring for Tom. We are aware that this policy has now changed following the RCA.
- Consistent failure of communication between all staff
- Reported insufficient staff levels
- Failure to escalate urgency of Tom's condition to critical care
- Action plans as a result of Care Quality Commission report April 2016 not implemented being an exact reflection of these failings reported 10 months prior.
- We find that antibiotic intervention should have been started at 18:50 as evidence showed 3 nurses showed (verbally) concerns of possible meningitis rash. SHO also considered condition as took action to research meningitis rash on computer.
- Evidence heard reports as long as no allergy to antibiotics they are able to be administer as a precaution as part of a differential diagnosis.

4 CIRCUMSTANCES OF THE DEATH

Please see record of Inquest and Circumstances of the death of Tom Cribley as found by the Jury (Meningococcal sepsis is a reportable disease and consequently the inquest was necessarily heard before a jury Article 2 was engaged due to the number of failures identified by Aintree University Hospital Trust and in [redacted] report (expert appointed to assist the Coroner) and a potential breach of the operational duty).

Copied from the Record of Inquest Section 3

18 February 2017 Upon arrival at Aintree hospital Accident and Emergency Department (AED) presenting complaints recorded. Rash observed but not recorded. Nurse noted staff shortages. Tom recorded as Cas 1 on whiteboard to be seen next. Made category 2 to be seen within 10 minutes by a consultant, as looked clinically unwell even though MEWS 0. 17:20 Tom verbally handed over to majors (AED) and placed in side room 2 with concerns of vomiting and diarrhoea and possible meningitis rash. Coordinating nurse failed to document rash although stated as really evident and stated Tom looked really unwell. 17:35 Pitstop nurse brings commode into side room 2 after bumping into Tom believing he did not look well enough to go to the toilet. He was not aware of Tom as no handover had been given. Nurse noted staff shortages. A loose stool was observed. Rash observed but not recorded. 17:40 Nurse verbally mentioned meningitis rash concerns to consultant who then carries out brief assessment including routine meningitis checks, without referring to observations previously taken. Diagnosis of gastroenteritis given. Consultant observed rash on entire back and shoulder. 17:52 Medication and bloods requested. 18:50 Tom receives paracetamol, piriton, anti-sickness and IV fluids. 18:40-18:50 approximate time recording due to failure of recording. SHO advised of possible meningitis rash and proceeds to check images on computer. Consultant advises to stop and check patient first. SHO does not complete full assessment. SHO checks rash on shoulder but does not record. 18:53 Bloods received in laboratory. 19:00 Night shift receives verbal handover of vomiting, rash on chest and neck. 19:25 Nurse records observations but does not record time. MEWS calculated as 3 but failed to escalate immediately. Rash observed on upper arm but not recorded. 20:00 SHO observes Tom in foetal position and describes as 'not as chatty and out of it' not recorded. SHO did not escalate concerns or raised MEWS recorded at 19:25 to senior consultant. 20:20 Nurse administers more IV fluids, is unaware of MEWS score and does not repeat observations. 20:35 Blood results phoned through from laboratory indicating grossly abnormal. Blood results recorded on a post it note but not transferred to patient's notes. Three options were given by the laboratory which included: incorrect patient, too small a sample or incorrect diagnosis ie did not fit clinical picture of gastroenteritis. Laboratory did not have clinical diagnosis on the system. Laboratory requested second blood sample. 20:35 Nurse passes on blood results to SHO who had been advised by consultant to prepare Tom for discharge with anti-sickness drugs. After discussion with consultant 3 attempts were made to take second set of bloods. Rash noted on arm but not recorded. 20:48 SHO takes second set of bloods. 21:00 Nurse states Tom is lying flat and is quiet, father becoming more anxious and asks for pain relief at 21:40. SHO prescribes medication without reassessing patient. 21:15 Second set of bloods received by laboratory. 22:25 Nurse takes set of observations, first taken since 19:25 when MEWS of 3 was recorded. Nurse makes immediate diagnosis of meningococcal sepsis, after observing rash on face, shoulder and legs. Notes respiratory rate high, Tom sat in chair looking distressed with pain in lower back and severe headache. Makes preparations to move immediately to resus. Observed petechial dots on feet and rash had changed

in morphology. Venous gas bloods taken which showed lactate of 18. 22:34 Laboratory phoned through to confirm grossly abnormal results which had deteriorated further given a MEWS of 5. 22:45 Antibiotics prescribed. 23:00 Antibiotics administered. 23:10 Critical care registrar bleeped. Consultant notes brownish patches starting to develop on face and other parts of body. Critical care registrar was not aware of the urgency of Tom's condition so did not bring drugs bag. 23:15 Critical care registrar arrives and takes over the care of Tom.

5 CORONER'S CONCERNS

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. –

A RCA revealed a number of failings by the Trust including in respect of some matters that had been previously raised by the Care Quality Commission and required action. The failings identified by the Trust and those found by the Jury included; inter alia failing to document important clinical findings for example the failure to document the rash that Tom presented with when he arrived at AED which was not recorded at triage. The failure to escalate the NMEWS (National Modified Early Warning Score) in a timely manner to medical staff and to repeat observations hourly in accordance with the NMEWS policy. The failure to complete a full "PIT STOP" review, the failure to review the initial diagnosis of gastroenteritis when Tom's condition continued to deteriorate, the failure of clinical staff to handover clinical concerns to each other and to medical staff including face to face handovers, the failure to escalate monitoring and management appropriately in particular following receipt of the first set of grossly abnormal blood results, the failure to administer antibiotic therapy until 23.00 hrs this even when Tom's condition continued to deteriorate and the rash that he presented with began to spread and appeared to change in both colour, size and location during which time Tom was becoming increasingly unwell, he had been a fit and well 28 year old prior to his attendance in AED. There was also an admitted failure to escalate appropriately and to convey the magnitude and severity of Tom's condition and deterioration to the Critical Care Team, who described him as being "in extremis" when the Critical care doctor arrived shortly after 23.00hrs. The care and treatment from 2300hrs onwards on 18/02/2017 was regarded as wholly appropriate but sadly Tom did not recover and he died on 20/02/2017.

Aintree University Hospital have put an action plan in place to address the failings identified within the RCA however such is the concern of the Coroner pertaining to the **training needs of clinical staff (doctors and nurses) in respect of the identification and treatment of sepsis and meningococcal sepsis in particular** that the Coroner requires a report and action plan which clearly identifies a systematic, consistent and comprehensive ongoing training programme which identifies not only the training plan that will be implemented across the Trust but also how the training plans implementation will be monitored in respect of consistency of approach, compliance and effectiveness.

The Trust has produced a number of action plans on previous occasions following Care Quality Commission Reviews, however, some of the failings identified in the issues touching the death of Tom Cribley have also been identified on previous occasions.

Robust monitoring and ownership of the training programme, implementation and review is required from the very top of the organisation up to and including the Trust Board. This leadership and ownership from the top will be fundamental to the achievement of meaningful and sustained improvements in the provision of education and training in this most challenging clinical area.

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 23 November 2018. 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. **Care Quality Commission- Clinical lead for Aintree University Hospital Trust**
2. **Public Health England- Training Director**
3. **NHS England – Training lead**
4. **Properly Interested Persons- The Family of Mr Tom Cribley (Deceased) Mr Alex Cribley (Tom's father)**
5. **Aintree University Hospital Trust Chief Executive**
6. **Clinical Director/lead of the Clinical Commissioning Group with responsibility for Commissioning care from Aintree University Hospital**
7. **Senior Officers with responsibility for doctors and nurses training at the GMC and Nursing & Midwifery Council (Registrant bodies)**
8. **Chief Coroner for England & wales**

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

Julie GOULDING
Assistant Coroner for
Liverpool and Wirral
Dated: 09 October 2018