

Mr Roger Hatch
HM Senior Coroner for North West
Kent
Maidstone Coroner's Court
Archbishop's Palace
Maidstone
ME15 6YE

Professor Stephen Powis
National Medical Director
6th Floor, Skipton House
80 London Road
SE1 6LH

7th March 2019

Dear Mr Hatch,

Re: Regulation 28 Report to Prevent Future Deaths
Name: Timothy Alastair MASON
Date of Death: 16 March 2018

Thank you for your Regulation 28 Report dated 26 October 2018 concerning the death of Mr Timothy Alastair Mason on 16 March 2018. Firstly, I would like to express my deep condolences to Mr Mason's family.

The Regulation 28 Report concludes Timothy Mason's death was due to the failure to diagnose and treat Mr Mason at Tunbridge Wells Hospital following his attendance at the Trust's emergency department on 16 March 2018. A contributing factor was that Mr Mason had not been vaccinated with the Men ACWY vaccine.

Following the inquest, you raised concerns in your Regulation 28 Report (Report) to NHS England and Maidstone and Tunbridge Wells NHS Trust regarding Mr Mason's management at the Trust on the day of his death and the fact that he had not been vaccinated against Meningitis C.

I am in receipt of a copy of the response to your Report from Mr Miles Scott, Chief Executive of Maidstone and Tunbridge Wells NHS Trust (Trust) and have seen the action plan produced by the Trust. I have asked the South East Regional Medical Director to follow this up directly with the Trust to ensure that the actions from this tragic incident are completed.

With reference to your final point, Saxonbury House Medical Group (Practice), and all GP practices that signed up to General Medical Services (GMS) enhanced services in 2015/16, were required to offer the vaccination by actively calling eligible young people age 18 years on 31 August 2015, and opportunistically offering the vaccine to those age 19 years on 31 August 2015, and up to the age of 25 years by 31 March 2016.

As part of the GMS contract the practice had a responsibility to ensure that administrative processes were in place for the service they signed up to, including adequate vaccination call and recall systems.

It would appear from Mr Scott's letter that [REDACTED], a GP partner at the practice, reported at the inquest, that, whilst Timothy did form a part of the cohort of patients who should have been invited to receive the meningitis vaccination, the practice was unable to evidence whether he had ever been invited for the vaccination. His medical records demonstrated that he had not received the vaccination. Furthermore, the practice did not opportunistically offer Timothy the vaccination during appointments with his GP in the following years, because the Medical Information System (EMIS) the practice relied on to prompt such reminders only offered reminders about selected vaccines and did not include Men ACWY unless specifically activated to do so.

As a result of this incident, the practice has acted to ensure that the vaccination has been offered to all eligible patients. I can also confirm that the practice has now switched on the necessary alerts prompting the offer for patients who have not received the Men ACWY vaccination. The practice has also written to EMIS requesting that Men ACWY is added to the list of vaccines flagged up in the alert box as a routine. All local practices have been written to and asked to check that the Men ACWY vaccination alert is activated and patients invited from the relevant cohort.

During 2018/19 GP practices have continued to opportunistically offer the vaccine to anyone up to the age of 25. This includes those who may have missed the opportunity to be immunised as part of the schools-based programme.

In 2019/20 NHS England, will continue to offer the opportunistic service and has committed to undertake a national review of the vaccination and immunisations arrangements (<https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf>) which will include a review and clarification of the expectations around call/recall arrangements, reducing the risk of this incident recurring.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely



Professor Stephen Powis
National Medical Director
NHS England