REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Chair - Coventry and Rugby Clinical Commissioning Group (CCG), Parkside House, Quinton Road, Coventry CV1 2NJ** **2. [redacted], Service Manager - Virgin Care Coventry LLP (Virgin Care), Stoney Stanton Road, Coventry CV1 4FS**
1	**CORONER** I am R Brittain, Assistant Coroner for Coventry.
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	**INVESTIGATIONS and INQUESTS** Vanessa Ferkova died, aged 2, on 16 January 2017 from meningococcus septicaemia. The inquest into her death concluded on 26 January 2018; I recorded a narrative conclusion (see attached). Sylvia Daniel died, aged 73, on 2 January 2018 from acute meningitis. The inquest into her death concluded on 16 May 2018. I recorded a narrative conclusion (see attached).
4	**CIRCUMSTANCES OF THE DEATH** **Miss Ferkova** Miss Ferkova had a non-significant medical history. She presented to Coventry GP Walk-in Centre (operated by Virgin Care) at 2pm on 16 January 2017 with her parents, having suffered from fever and vomiting that morning. A receptionist took down details of her illness and recorded that Vanessa looked 'pale'. The information recorded did not meet the 'red or yellow flag' conditions which would have prompted prioritisation of her care. Her parents stated that Vanessa vomited in the waiting room, which would have prompted prioritisation but they were not aware of this 'flag' and did not report this incident. Vanessa also developed a rash whilst waiting to be seen which, if 'non-blanching' would have also prioritised Vanessa's assessment. Her parents' evidence was that the development of a rash was raised to the receptionist, although this was not her recollection of events. As such, there was no clinical assessment until Vanessa was seen by a nurse shortly after 4pm. At that time she was recognised to be very unwell and likely suffering from meningococcal septicaemia. She was given antibiotics and and an ambulance was called. In the ambulance, shortly after 4.30pm, Vanessa went into cardiac arrest. Unsuccessful resuscitation attempts were made, including on arrival at hospital shortly

	after her arrest, and she died at 5.11pm. I heard evidence from the treating hospital paediatrician that it was likely Vanessa was suffering from compensated shock on her arrival to the walk-in centre and that, had observations been undertaken at this stage, this would have been recognised, treated and Vanessa would have survived. The paediatrician set out that recording clinical observations was a 'vital patient safety tool' in the secondary care setting. I heard from Virgin Care that, unlike in the secondary care setting, they are not commissioned to undertake clinical triage and that nor is there a timeframe within which patients are required to be initially assessed. **Mrs Daniel** Mrs Daniel presented to Coventry Walk-in Centre on 1 January 2018 with symptoms reported by her family to include, amongst others, a stiff neck/neck pain. Her daughter stated in evidence that she completed a handwritten registration form at reception which included this detail. However, electronic documentation recorded by the receptionist did not include reference to Mrs Daniel's neck. Virgin Care have subsequently confirmed that the handwritten forms are not retained at the walk-in centre and this form would have been destroyed. Mrs Daniel was seen by a doctor after a wait of approximately 90 minutes. Her family set out that they had raised concerns she had deteriorated and needed to be seen prior to this but that this was not acted upon by reception staff. The doctor who consulted with Mrs Daniel diagnosed her with an ear infection and prescribed antibiotics. There was differing recollection between the family and the doctor as to whether neck symptoms were specifically referred to in the consultation. The doctor set out that, had they been part of the history provided, he would have undertaken a specific examination to assess the cause. He was clear that the information provided by reception made no reference to neck symptoms and demonstrated this by reference to the electronic documentation. Mrs Daniel's family stated that on the way home she became more confused and unsteady. On arriving at her home Mrs Daniel went to sleep but was found deceased the following morning, after contact could not be made by her family.
5	**<u>CORONER'S CONCERNS</u>** During the course of these inquests 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** following the inquest into Miss Ferkova's death were as set out in the attached Prevention of Future Death Reports which I addressed to NHS England and the Care Quality Commission (CQC). I did not write to Virgin Care at that time, as they were to undertake a review as to whether 'initial' clinical observations should be introduced by their service. This review concluded that '...there is not evidence to support such an intervention currently…' I was provided with responses from NHS England and the CQC (also attached) which demonstrated an intention to introduce new standards for facilities, such as the Coventry Walk-in Centre (which will be called Urgent Treatment Centres (UTC)). One such standard will include clinical assessment within 15 minutes of attending a UTC. NHS England set out that all UTCs will be expected to have a plan in place by March 2019 and will be operational by 2019. The CQC set out a change to their inspection

	framework which would include a recommendation for patients to receive a clinical assessment within 15 minutes. This was stated to 'go live' from 1 April 2018. However, in response to this issue Virgin Care, through its representative, set out as follows: "The onus is for the commissioners (the relevant CCG) , rather than the providers (eg Virgin Care), to take (sic) ensure that the appropriate service is being commissioned. We understand that the local commissioners are reviewing the provision of urgent care services in the community. We trust that such a review will include the revised NHS England guidance." 1. I am concerned that this standard is being introduced to address clinical risks but Virgin Care do not intend to change their service to address this risk but are instead awaiting a change in their commissioning arrangements. I am concerned that future deaths could arise in this circumstance. The **MATTERS OF CONCERN** following the inquest into Mrs Daniel's death are related to the initial assessment/registration/non-clinical 'triage' process operated by Virgin Care. 2. I am concerned that some information provided by Mrs Daniel's family was not transcribed by the reception team, meaning that it was not available in written form to the clinical team as part of the initial 'paper' triage process and at the later formal consultation. 3. Related to this, I am also concerned that an important part of the medical records (the handwritten form completed by patients/families on registration) is destroyed, rather than added to the notes. The fact that information provided directly by patients/families is not available to clinicians is one issue that arises, another is that review of incidents, such as Mrs Daniel's death is hampered where 'primary evidence' is unavailable. 4. My final specific concern relates to the process whereby patients/families are asked to let the reception team know if the patient is deteriorating, or if they are concerned that earlier prompt review is required. I heard evidence that such concerns were raised but no action was taken. This seemingly runs counter to Virgin Care's own 'flagging' system. My overarching concern is that the current process of initial assessment/registration/non-clinical 'triage' and yellow/red flags is unsafe. Future deaths may result, prior to the planned compulsory introduction of clinical assessment in 2019, if action is not taken either by Virgin Care directly, or by the CCG.
6	**ACTION COULD BE TAKEN** In my opinion action could be taken to prevent future deaths and I believe that the addressees 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 20 August 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, Miss Ferkova's family, Mrs Daniel's family, the CQC and NHS England. 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	25 June 2018  **Assistant Coroner R Brittain**