William David Patrick HEWES - determination on 27.03.25

This has been an inquest on behalf of Our Sovereign Lord The King by me, Mary Elizabeth Hassell, Senior Coroner for Inner North London, touching the death of William David Patrick Hewes, who died on 21 January 2023 at Homerton University Hospital in London. I make a narrative determination as follows.

"William Hewes was a 22 year old fit and healthy young man with no co-morbidities, who became unwell at approximately 1.30pm on the afternoon of Friday, 20 January 2023. He felt cold and had a headache. He felt worse during the day. He went to bed for the night at 10.30pm. About an hour later, he got up to tell his mother that he now felt very unwell. He was unable to pass urine and he showed her what he thought was bruising on his belly.

William's mother, a consultant paediatrician, recognised a non blanching rash. She suspected meningococcal sepsis. She rang the emergency department (ED) of the hospital where she worked, to warn them that she and her son would arrive shortly. She explained to the ED registrar that she was a consultant paediatrician at that hospital, she described her son's signs and symptoms and she said she thought he had meningococcal sepsis. Mother and son left home without delay and arrived at the hospital at 12.06am on the morning of Saturday, 21 January 2023. William was triaged and then medically assessed promptly. His mother immediately articulated the requirement for antibiotics.

By the time of his assessment in hospital, William had an almost eleven hour history of being unwell. He had non blanching rashes and cold peripheries. He was hypotensive (systolic blood pressure of 85), tachycardic (heart rate of 119) and acidotic (venous lactate of 7.2). He was actively vomiting, he had a severe headache and he was in intense pain in his right flank. He was still alert and speaking. He was immediately recognised by all medical and nursing staff with care of him as a patient with life threatening sepsis.

The ED registrar who assessed William gave an instruction for ondansetron (an anti sickness medication), Hartmann's solution (to replace body fluid), morphine (for pain relief) and paracetamol (to lower his temperature). She then checked the correct antibiotic and dose, and also gave an instruction that ceftriaxone (an antibiotic) and acyclovir (an antiviral) be given. All these instructions were given verbally, an acceptable method of prescribing drugs in an emergency situation, with the doctor writing up the prescriptions in the medical record a little later.

However, although the ondansetron, Hartmann's, morphine and paracetamol verbal instructions were given one-to-one (ED registrar to William's ED resuscitation nurse), the ED registrar gave the ceftriaxone and acyclovir verbal instructions when two nurses were present and she did not address either nurse by name. Neither nurse heard the instruction and neither nurse responded. The loop of communication was not closed.

William's ED resuscitation nurse was aware that he was suffering from sepsis. She was aware of the sepsis six bundle. She was aware that a patient with sepsis should be given an antibiotic immediately and in any event within one hour. She did not ask the ED registrar about giving William an antibiotic.

The verbal drug instructions were all issued between 12.31am and 12.35am.

William's ED resuscitation nurse gave the ondansetron, Hartmann's, morphine and paracetamol. When the nurse was administering these drugs, William's mother, known by the nurse to be a consultant paediatrician at that hospital, asked the nurse if she was administering the antibiotic. The nurse said yes, though as far as the nurse was aware an antibiotic had not even been prescribed let alone administered. The nurse was not being deliberately untruthful, but she did not listen properly to what she was being asked and so she gave entirely the wrong answer.

The first litre of Hartmann's went up at 12.50am. At 1.15am, a medical registrar came to assist the ED registrar. It was after his attendance that the discovery was made that the antibiotic and the antiviral had not been given. The ceftriaxone and acyclovir were then administered at 1.25pm. Following the administration of the first litre of fluid, there was a transient increase in blood pressure and drop in heart rate, but it was not sustained. The second litre of Hartmann's went up at 1.30am. Between approximately 2.05 and 2.10am, the medical registrar asked for William to be catheterised. When William had not passed urine by 2.20am, the medical registrar asked for a third litre of fluid to be administered.

The ED registrar had promptly asked for an intensive care consultation with a view to transferring William to the intensive treatment unit (ITU), making the request even before she had called the medical registrar. The ITU registrar assessed William at 1.38am. She did not accept him for transfer to the ITU.

Transferring William to intensive care would have provided one-to-one nursing from a skilled ITU nurse. However, the other treatment that he would have been given in intensive care, such as an arterial line, frequent blood gases, an early urinary catheter and fluid challenge, were available in the ED resuscitation unit. Whilst the ED registrar was of the firm view that William needed transfer to ITU and she would have much preferred this to take place as soon as possible, she also thought that the ITU registrar's decision not to transfer *at that time* was reasonable. There was therefore no strong disagreement between the teams at that stage and so it was not mandatory for the ITU registrar to call her ITU consultant after she saw William at 1.38am.

At 2.42am, the ED registrar asked the ITU registrar to return to the ED resuscitation unit, pointing out that William had now developed an oxygen requirement and had no urine output. The ITU registrar did return, although only after a robust conversation between them and after the ED registrar had obtained the medical registrar's support for her request.

The three teams all knew the plan for William of fluids, medication and blood cultures, but there was no clear record made of a plan for the timing and quantity of fluids to be given, and between 1.20am and decision to transfer to ITU it was not clear whether the ED registrar, the medical registrar or the ITU registrar had ultimate oversight of William's care.

The decision to transfer to ITU was made at 3.09am. William was then transferred swiftly, arriving at 4am. Thus the national standard of a maximum of four hours to transfer in such a situation was not breached. With hindsight, by then his condition was probably irretrievable.

William Hewes died at 2.22pm on Saturday, 21 January 2023, from invasive meningococcal septicaemia, a natural cause of death.

When he attended hospital just after midnight on the day he died, William's life threatening condition was recognised, but he did not receive immediate antibiotics, immediate and repeated fluid boluses with repeated reassessment of capillary refill, heart rate, blood pressure and serial lactate measurement after each intervention, then vasopressors or inotropes, followed by early haemofiltration if needed, with the urgency that he should have.

However, he was already very unwell when arrived, and it is unclear whether, if he had been administered all appropriate treatment promptly, his life would have been saved."

I intend to make a prevention of future deaths report.
That concludes this inquest.