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30th May 2025

Mr D Heming
Senior Coroner for Cambridgeshire & Peterborough
The Coroner's Office
Lawrence Court
Princes Street
HUNTINGDON
PE29 3PA

Dear Sir,

Inquest into the Death of Christian HOBBS

I refer to your Regulation 28 Report.

Before I respond to the specific issues raised in the Report, there are a few key points that I believe it necessary to highlight.

Firstly, the inquest hearing into Christian's death did not commence until October 2022, almost five years after Christian's tragic death. It was then part adjourned and resumed a year later in October 2023 with the Conclusion delivered in October 2024, almost seven years after Christian's death. By this time, the Trust had already made numerous changes and quality improvements based upon its internal investigation and lessons learned from this case.

Secondly, our own investigation highlighted that the Emergency Department Registrar who assessed Christian on his admission to ED failed to diagnose cardiogenic shock caused by his undiagnosed cardiomyopathy. Instead, the diagnosis given was septic shock. However, as clinicians, whilst we often see patients who do suffer from cardiogenic shock, this tends to be in much older patients with ischaemic heart disease. Cardiogenic shock in a young person who has essentially been previously fit and well is extremely rare and most clinicians will never come across such a situation in their entire careers. The extreme rarity of this condition makes it extremely difficult to diagnose, especially in a situation which is time critical. Conversely, sepsis is a far

more common cause of admission in young people of Christian's age, and it is widely recognised by healthcare staff and the public alike.

Moving on to the specific issues that you have raised in your Report:-

A. **Cardiogenic shock**

Our focus as a Trust since this case has been to concentrate on education and training of our staff to be aware of, and to recognise, cardiogenic shock in patients of a young age, especially in the ED setting, and to escalate accordingly.

B. **Echocardiography**

This case was not caused by an inability to perform an echocardiogram. Had cardiogenic shock been suspected, a Consultant Intensivist or an on duty Medical Registrar, who was also a trained Cardiology Registrar, could have performed the procedure. As was explained at the inquest hearing in October 2023, it is possible to train more clinicians to perform echocardiograms. However, for a clinician to maintain their accreditation to perform echocardiograms, it is obligatory to perform a certain number of echocardiograms annually. While Cardiologists and Intensivists routinely meet this requirement, it remains challenging for other specialty clinicians, including ED. Nevertheless, our trainees now receive echocardiography training.

C. **Fluid Management**

The Trust acknowledges historical concerns regarding fluid management and the maintenance of fluid balance charts, but significant training and education have since been provided. In Christian's case, gaining intravenous access was challenging due to hypoperfusion caused by cardiogenic shock, resulting in fluids being administered later than ideal, leaving minimal time to evaluate the response.

D. **Team Interactions**

As a result of the time it took for the inquest to take place, several clinicians were no longer working at the Trust by the time the hearing was commenced. Significantly, the ED Registrar was no longer working in this country and, despite efforts by your Office, it was not possible to locate him in order for him to give evidence regarding the events which occurred on the 26th December 2017. His evidence would have been crucial, as he was the clinician who initially assessed Christian and arrived at the diagnosis of sepsis secondary to a chest infection. Given Christian's symptoms, an infection was plausible and may have precipitated heart failure leading to cardiogenic shock. However, his critical condition on admission was not fully appreciated. Had this been recognised, existing escalation mechanisms, including an urgent review by the ED Consultant, who was also an Intensive Care Medicine Consultant, could have been utilised. Following a referral by ED to the General Physicians, patients are normally seen in time order unless there is a specific concern regarding the patient's condition. In those circumstances, the General Physicians would have been asked to see Christian immediately. The more likely scenario in Christian's case is that the Consultant in charge of ED that day would have been asked to see the patient on an urgent basis. The

mechanisms are present for escalation, but the issue was a failure to recognise that Christian's poor condition was due to cardiogenic shock.

E. Radiology Within NWAFT

The ED Registrar requested a number of investigations after assessing Christian. One of these investigations was a chest x-ray. This was performed after the assessment had been completed and Christian referred to the General Physicians. By that stage, the ED Registrar was treating other patients and he therefore did not view the chest x-ray.

Although there is some evidence to suggest that the chest x-ray was viewed by a member of the Medical team before they had the opportunity to assess Christian, no gross abnormality was noted at that time. The x-ray was an AP view and it is not possible to accurately assess the size of the heart in such a projection.

Plain films are usually formally reported within 24-48 hours. Furthermore, where necessary, a clinician can also request an urgent formal report from a Trust Radiologist, 7 days a week.

G. Blood Gases/Elevated Lactate

The sepsis guidelines are clear and once sepsis is suspected a venous blood gas should have been obtained when the initial blood samples were obtained at 19:00h. The Trust has since expanded its sepsis education and training, employing dedicated sepsis nurses who deliver the education and training, and monitor adherence to protocols and hold bi-monthly sepsis meetings.

H. Critical Care

Your concern here appears to relate to a case at Hinchingbrooke Hospital from 2019. I cannot see any concerns regarding the care provided to Christian by the Critical Care clinicians. Christian was managed entirely within the Emergency Department at Peterborough City Hospital. Following his cardiac arrest, the ICU clinicians took over his care and were responsible for resuscitation.

I. Differential Diagnosis

The diagnosis in Christian's case was one of sepsis/septic shock with cardiogenic shock overlooked due to its rarity in young patients. Differential diagnoses are a fundamental part of medical training and we are not aware of this being a recurring theme.

J. Sepsis Pathway

I have dealt with the issue of sepsis in point G above.

K. Anti-emetic medication

The paper referenced from July 2024, seven years after Christian's death, suggests potential risks associated with Cyclizine. Cyclizine is a very commonly used anti-emetic. It is possible that it may not have been used if a diagnosis of cardiogenic shock had been made. However, as explained previously, at the

time Cyclizine was prescribed it was not known that Christian had a cardiomyopathy and was in cardiogenic shock. The working diagnosis was sepsis. Clinicians in both ED and ICU have now been made aware of the potential complications of Cyclizine.

L. ECG analysis

All ECGs performed in the Emergency Department must be signed off by a Consultant or Registrar. Christian's ECG on admission revealed a sinus tachycardia. ECG training remains an important part of training for resident doctors.

M. Record-keeping

The maintenance of good documentation is something which is highlighted to all clinicians during their training and postgraduate education. In addition, the Trust introduced the Symphony medical records system (digital) into the Emergency Department in December 2018 and this has resulted in improvements in record-keeping. The issue of the jugular venous pressure and capillary refill time is not a matter related to documentation; it is an issue which relates to an incomplete examination by the ED Registrar. Once again, it is difficult to comment upon this in the absence of any evidence from the clinician. However, these issues have been highlighted to staff in ED.

N. Data from Emergency Department Alarms

The parameters at which alarms are sounded can be adjusted by staff on a temporary basis. Notwithstanding this, the monitors are still visible to staff in the Resuscitation area. As was explained at the inquest, the Emergency Department has subsequently installed a central monitoring area with printers. There is therefore no problem in retaining or printing off data if this is required. Unfortunately, in Christian's case, the Trust was not informed of any concerns in this respect until some considerable time after Christian's death. The monitors that we had at that time would needed to have been interrogated prior to being used on the next patient. This is no longer an issue with the new equipment that we have but once again data will only be stored for a limited period of time.

O. Learning from HSSIB Reports

The issues raised in the 2019 report align with NICE Guidelines and the National Early Warning Score (NEWS) tool developed by the Royal College of Physicians, both of which support early detection of acute illness and timely escalation of the deteriorating patient. I can confirm that the Trust's Physiological and Neurological Observations Policy (Version 6, approved on 22 August 2024) is based upon these national guidelines. Additionally, as part of the Trust's PSIRF (patient safety incident response framework) priorities, we have commenced an improvement plan focusing on the NEWS2 score to enhance the management of deteriorating patients. Any patient who may have been harmed through deterioration, is discussed at the weekly PSIRP meeting with a view to proceeding to a formal investigation of the case.

You will, of course, also be aware that Martha's Rule (in relation to escalation) has been introduced at a national level and introduced on both our main sites.

P. Patient Safety In Some Trust Areas

It is unclear which specific concerns are being referenced or how these relate to this inquest. However, since January 2017 your Office has issued five Regulation 28 Reports directed at the Trust. All recommendations contained within those reports have been actioned. The Trust is also subject to regular reviews by the CQC and we work with the CQC to ensure all recommendations are implemented.

S. NWAFT Paediatric Mortality Review

Christian's death was initially discussed by the Paediatricians at a Review meeting on the 22nd February 2018 but as the results of the Post Mortem were not yet available, a further discussion took place on the 26th June 2018. At that point, no concerns had been received regarding Christian's management in ED. At the meeting it was noted that the PM findings had been of a possible intrinsic cardiomyopathy. The Consultant Paediatricians therefore felt that as a result of this finding other family members should be screened for a possible metabolic cause. The GP Practice was therefore contacted. The GP confirmed that the family had already been referred for screening.

I hope that this response does assure you that there have been significant changes implemented at the Trust since Christian's death in 2017. We acknowledge the lessons learned from this tragic event and remain fully committed to ensuring they are reflected in the ongoing training and education of our clinicians.

Yours faithfully,

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Chief Medical Officer, Responsible Officer & Consultant Physician