



Terence Carney  
Solicitor  
Senior Coroner  
Gateshead & South Tyneside.

35 Station Road  
Hebburn  
Tyne & Wear  
NE31 1LA  
Tel: [REDACTED]  
Fax: [REDACTED]

## Regulation 28 – Report to Prevent Future Deaths

### **This Report is being sent to:**

Professor Sir Bruce Keogh, National Medical Director, NHS England, Rm 504 Richmond House, 79 Whitehall, London SW1A 2NS

Professor Ian Cummings OBE, Health Education England, 1<sup>st</sup> Floor, Blenheim House, Duncombe Street, Leeds LS1 4PL.

Sir Andrew Dillon CBE, National Institute for Clinical Excellence, Midcity Place, 71 High Holborn, London WC1V 6NA

Farnham Medical Centre, 435 Stanhope Road, South Shields, Tyne and Wear NE33 4QY

South Tyneside NHS Trust, Harton Lane, South Shields, Tyne & Wear NE34 0PL

Newcastle NHS Trust, Royal Victoria Infirmary, Queen Victoria Road, Newcastle upon Tyne NE1 4LP

Sunderland NHS Trust, Kayll Road, Sunderland SR4 7TP

Newcastle & Gateshead Clinical Commissioning Group, Riverside House, Goldcrest Way, Newcastle upon Tyne NE15 8NY

South Tyneside Clinical Commissioning Group, Monkton Hall, Monkton Lane, Jarrow, Tyne & Wear NE32 5NN

### 1 **Coroner**

I am Terence Carney, Senior Coroner for Gateshead & South Tyneside.

### 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.

<http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7>

<http://www.legislation.gov.uk/uksi/2013/1629/regulation/28/made>

<http://www.legislation.gov.uk/uksi/2013/1629/regulation/29/made>

### 3 **Investigation & Inquest**

On 12<sup>th</sup> April 2014 I commenced an investigation into the death of Tamara Mills aged 13. The investigation concluded at the end of the inquest on 15<sup>th</sup> October 2015. The conclusion of the inquest was

**A premature death contributed to by a lack of appreciation and/or reaction to the deteriorating nature of her chronic respiratory condition and the absence of any planning to direct, monitor, manage and co-ordinate her care, improvement, its sustainability and prevent her death.**

### 4 **Circumstances of the Death**

Tamara Mills was diagnosed with Asthma at the age of 9 months. On innumerable occasions throughout the next thirteen years of her life she suffered repeated acute exacerbations of this condition. She was attended throughout this period on innumerable occasions – 47 – in the last four years of her life by a series of medical personnel at primary and secondary level and received treatment, directed to alleviate the symptoms of the immediate presenting and acute episode. There was no appreciation that each episode was a deteriorating step in her overall respiratory well being. On 7<sup>th</sup> April 2014 Tamara suffered from breathing difficulties and it was felt she should be admitted to hospital and was transferred to the Royal Victoria Infirmary. Several hours later she was discharged to her grandparents address as they lived in a bungalow and it was felt the stairs at her home address would be too much for her. On 10<sup>th</sup> April 2015 Tamara felt she had a chest infection and a GP appointment was made for 11<sup>th</sup> April, however, during the night 10<sup>th</sup>/11<sup>th</sup> April Tamara called for assistance as she was struggling to breathe. Paramedics were called but sadly Tamara deteriorated and died.

### Coroners 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:-

1. The care management and treatment of this child on the innumerable occasions she presented with an exacerbation of asthma, was centred solely on treating the immediate presentation as an isolated acute event seeking its stabilisation and returning her to the care of her family.
2. There was :-
  - i) No co-ordinating record of these occasions
  - ii) No analysis of the frequency or circumstances of the events
  - iii) No analysis of the medication or level of medication prescribed
  - iv) No determination of its effectiveness the frequency or regularity of its use
  - v) No appreciation of the deteriorating nature of her respiratory condition
3. Despite the presence of a significant number of health care professional involved in her care and some frequently, no single individual assumed management for her care overall
4. In the absence of no one individual assuming responsibility for her care, there was no plan directed towards her long term management and care identifying the chronic nature of her condition, seeking a sustained and balanced level of treatment, control and resolution of the recurring episodes.
5. Insofar as planning occurred it was in the last six months of her life and was in the form of an emergency plan directed towards the next and apparently accepted inevitable acute event, but not as a part of the necessary strategy to control and avoid such events.
6. Not only did those advised of such a plan fail to understand its limited objective they misinterpreted its purpose and consoled themselves in the false belief there was a purposeful strategy designed to protect this child in the long term.
7. In and of itself this episode demonstrates a profound and woeful indication of the lack of understanding of how this condition, its recurring nature can and should be managed by someone with the proper training and understanding of this chronic respiratory disease.
8. Two further areas of concern presented, inter related but independently significant and critical in this matter :
  - A) Tamara's mother readily presented her child for care in an out of hours to primary care and secondary care, but there was a lack of effective communication between these services, either at the time of referral or after consultation and treatment.
  - B) Evidence was also received of the development of a Tertiary service designed to improve medical care in the area of paediatrics.
    - i) There was a singular lack of understanding by practitioners of how referrals to the service were to be made and once made an anxiety that the receiving trust not be seen to be acquiring a patient at the expense of the referring trust. The net result of this inhibition a further fragmentation in the care and management of the patient.
    - ii) Within this service there were and indeed are specialist Respiratory Physicians who because of their level of expertise could and did demonstrate their ability to make a difference if they had been permitted in one instance to assume long term management of the child's care and
    - iii) More tragically in another because she was referred to the hospital but not to the service and therefore not to the Tertiary Specialists, managed only as an acute presentation
9. Tamara was never formally referred to this level of service.
10. The National Review of Asthma Death (NRAD) 2011-2014 was published in a report entitled **Why Asthma still Kills** on the 6<sup>th</sup> May 2014, a month after Tamara's death. The Review's evidence based conclusions and recommendations exemplify and underline the same missed opportunities and poor practice which lead to Tamara's death.
11. The conclusions of the Review would not of themselves have impacted on the events leading to Tamara's death but in the context of seeking to avoid future deaths, the Review and the evidence of Tamara's Inquest identify a need by both national and local agencies to revisit the recommendations of the Review, the formal substance of training identified as appropriate for the care and treatment of Asthma, the nature of that disease and the strategies essential for the long term management, care and prevention of uncontrolled re-occurring attacks.
12. It is right to acknowledge that the local Trusts in this matter have responded to the criticism directed towards them and sought to identify better practices for the future, their experience needs to be shared by and with other medical care professionals on a continuing basis and their resolve to do so evidence of their commitment , the lessons that apparently have been learnt.

13. There are undoubtedly resource issues implicated in this matter but a demonstration of resolve and an effective lead given by the Department of Health and those involved in the provision of Health Service guidance and education nationally would demonstrate a universal resolve to standardise the care of chronic asthma patients and to make paediatric asthma death “a never event”.

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 24<sup>th</sup> December 2015. 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 & Publication**

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [REDACTED] and her Solicitor Browell Smith & Co {and to the Local Safe-Guarding board (where the deceased was under 18)}. I have also sent it to the Healthcare Quality Improvement Partnership, Royal College of Physicians, 11 St. Andrews Place, Regents Park, London NW1 4LE who may find it useful or of interest.

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.

**Date: 29<sup>th</sup> October 2015**

{Signature}



**Senior Coroner – Gateshead & South Tyneside**