ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Mr Simon Stevens. The Chief Executive of NHS England** 2. **Mr Jeremey Hunt. Health Minister Department of Health** 3. **Chief Coroner** 4. [redacted]
1	**CORONER** I am Mary Burke, Assistant Coroner, for the Coroner area of West Yorkshire Western
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 20
3	**INVESTIGATION and INQUEST** On 9th January 2013, this jurisdiction commenced an investigation into the death of Kirsty Childs, Age 20. The investigation concluded at the end of the inquest on 7th April 2016. The conclusion of the inquest was a narrative verdict:- Kirsty Louise Childs died at home from septic shock caused by an undiagnosed and untreated mesenteric venous thrombosis. Kirsty and her mother telephoned NHS Direct on a number of occasions between 31 December 2012 and 2 January 2013 for advice and assistance due to a range of symptoms which Kirsty was displaying. Despite these telephone conversations Kirsty was not admitted to hospital. If she had been admitted to hospital by the morning of 1 January 2013 and received definitive hospital care, the likelihood is that Kirsty would have survived. The cause of death was:- 1a) Septic Shock b) Small Bowel Infarction c) Superior Mesenteric Venous Thrombosis
4	**CIRCUMSTANCES OF THE DEATH** Kirsty Childs was a 20 year old single parent who lived with her 2 year old daughter and parents in Denby Dale, Huddersfield. She had no significant medical history and was not on any prescribed medication. On Christmas Day 2012, she reported to her parents as not feeling well but with no specific symptoms. On Sunday 30th December she began to experience severe abdominal pain, sickness and diarrhoea. Her mother contacted NHS Direct (the out of hours service operating at the time) at 20.35 hours on 31st December, because her daughters symptoms were

worsening.

This was the first of 18 phone calls made and received by Kirsty and her family with NHS Direct, the Ambulance Service and the out of hours GP service, over the next 2 days in an attempt to obtain appropriate advice and care for Kirsty.

The initial call was taken by a Health Adviser (as all initial and repeat calls were to the service). The Health Adviser (who is not medically qualified) in undertaking an assessment selected the incorrect computer generated questionnaire, which resulted in the call being given lower priority for a call back by a Nurse Adviser. Kirsty's mother phoned the service again at 1.09 hours, now 1st January, as no call back had been received.

The Health Adviser did not appear to undertake a review of the record made of the initial telephone call (something which appeared to be the case on every phone call to the service) but proceeded to undertake a new assessment. Kirsty's mother was advised that a Nurse Adviser would call back within 1 hour.

In fact, a call was received by a Nurse Adviser within half an hour. Kirsty was asked again to detail her symptoms which she did, and added that she had noticed blood in her bowel motion and describes her bowel motion as being really dark brown. The Nurse Adviser also worked through a pre-determined computer generated questionnaire, selected after hearing the patient's symptoms and identifying the most serious. The Nurse Adviser concluded that Kirsty was suffering from a bug and she should self -care, and advised that if her symptoms worsened, she should phone the service back.

I heard evidence from an independent Vascular Surgeon that the Nurse Adviser should have asked more questions surrounding the presence of blood in Kirsty's bowel motion. He indicated that if these questions had been asked it should have become clear that Kirsty was not suffering from a gastrointestinal bug, and that arrangements should have been made for Kirsty to be reviewed by a Doctor, either being assessed at home by the emergency out of hours General Practitioners service, or, referred to her local Accident and Emergency Service. He confirmed that if this had happened, it is likely that Kirsty would have been admitted to hospital, undergone investigations and diagnosed with her actual condition, a superior mesenteric venous thrombosis, which he considered at this stage was treatable and it is likely Kirsty would have survived.

Kirsty herself contacted NHS Direct 4 hours later at 5.45 hours, reporting that her symptoms had worsened, she had noticed blood in her vomit and she was very dizzy. Once again, the call was taken by a Health Adviser who did not appear to review the record of earlier calls made. A new assessment using a selected pre determined questionnaire was made. Kirsty endeavoured to answer the questions asked of her. She reported symptoms of feeling cold, but at the same time sweating and feeling clammy, which are recognised symptoms of shock. The Health Adviser endeavoured to put the call though to a Nurse Adviser without success. A Nurse Adviser phoned back very quickly. Kirsty reported symptoms of very severe abdominal pain which was getting worse, blood in her last bowel movement and in the last half hour had vomited dark red blood, although she had been sick subsequently with no blood present, her skin felt cold, but she was perspiring.

	The Nurse Adviser appears not to have reviewed previous records of earlier calls. She chose to override the recommended conclusion of the selected questionnaire which was that Kirsty should attend an Accident and Emergency Department. She advised Kirsty that she was suffering from a bug and should self- care. The independent Vascular Surgeon expert who gave evidence indicated that he would have expected Kirsty to have been referred to hospital and if she had, it is likely she would have survived. No call was made by Kirsty or her family to NHS Direct during the course of the day on the 1st January. Kirsty spent most of the day in bed, her symptoms continued she was not eating, she occasionally was being sick, but was endeavouring to sip fluids. During the afternoon Kirsty's mother found her on the floor near her bedroom. She appeared very weak. At 1.00 am, now the 2nd January, Kirsty asked for her mother's further help to take her to the toilet. As she assisted her, Kirsty had a vacant expression, she had difficulties breathing and she was unable to stand. Her mother proceeded to phone NHS Direct again. The call was once again taken by a Health Adviser who followed the same procedure as in previous calls. Kirsty was having difficulty answering the Advisers questions. A decision was taken for Kirsty to be further reviewed over the telephone by a Nurse Adviser. A subsequent internal review identified that not all questions from the pre-determined questionnaire were asked. If they had been, the internal review concluded that Kirsty may have been referred to Accident and Emergency. Kirsty received a call back from a Nurse Adviser. Once again, no review of earlier call information appears to have taken place. Kirsty was required to provide all information afresh. She described her vomit as being black throughout the day. The Nurse Adviser stated that Kirsty needed to be taken to Accident and Emergency to be reviewed. The Nurse Adviser made no enquiry if anyone was able to transport Kirsty to hospital, and the call was ended abruptly. Neither of her parents were able to take her to hospital, and Kirsty described feeling too weak to make the journey. Her mother therefore phoned for an ambulance, the call was taken by an Emergency Medical Dispatcher (who is not medically qualified). The equivalent to the Health Adviser within the NHS Direct service. Kirsty's mother made it clear at the beginning of the conversation that NHS Direct had directed that Kirsty should attend Accident and Emergency. However, the Emergency Dispatcher did not have the authority to despatch an ambulance based upon the recommendation of NHS direct. Once again, Kirsty was asked to describe her symptoms, in order that the most appropriate questionnaire was chosen and answered. A subsequent internal review confirmed that an incorrect questionnaire was selected. If the correct one had been chosen, evidence given at the inquest indicated that an ambulance would have been despatched to respond within 30 minutes. As it was the incorrectly chosen questionnaire directed a referral to a Clinical Adviser. Kirsty received a call back at 2.32 2nd January from a Clinical Adviser. It was made clear to them by Kirsty's mother that NHS direct have recommended hospital attendance. Questions were asked, but not all of Kirsty's symptoms were identified. Once again general questions were followed by a selected questionnaire. The answers resulted in a recommendation of attendance at Accident and Emergency as soon as possible.

	However, the Nurse Adviser chose to override the recommended course to be followed as she considered that Kirsty was suffering from a Norovirus viral infection and that she should not attend Accident and Emergency, she thought it best that Kirsty should not attend an Accident and Emergency unit, because there may be a lengthy delay in her seeing a doctor. She therefore advised that Kirsty should phone her own GP practice to arrange an out of hours GP review. West Yorkshire Ambulance Service had no direct arrangements with the out of hours GP service. The Nurse Adviser, therefore, had no means of ensuring that Kirsty would be seen by a doctor and no knowledge of how quickly this would occur. As a result Kirsty and her family were being referred to a completely separate organisation who had no direct access to details of the log of pre existing calls made and received. The independent Vascular Surgeon, who gave evidence at the inquest, indicated that by this stage Kirsty was critically ill. She should have been admitted to hospital, but, if she had been it is unlikely she would have survived. Kirsty's mother then endeavoured to seek further help for her daughter. A recorded message at her GP's provided contact details for West Yorkshire urgent care a service which was provided co-incidentally at the time by a section of NHS Direct. What Kirsty and her family were expecting is for an out of hours GP to attend their home. What actually happened was exactly the same process as had already happened on numerous occasions already. A Health Adviser taking the call, and proceeding through a questionnaire process, with no access or review or previous computerised details recorded. Once again subsequent internal review identified that the wrong questionnaire was selected resulting in a lower prioritisation being applied. Once again a Nurse Adviser rang the family, From the transcripts of the calls it is identified Kirsty was having difficulties breathing. The Nurse Adviser was made aware that previous calls had been made. The Nurse Adviser advised that someone would ring the family back. When this call occurred the family were offered an appointment at a GP drop in centre some miles from their home. The family explained that Kirsty was not well enough to attend and was now incapable of standing. The family ask if a GP could make a domiciliary visit, they were advised this was not possible. Kirsty and her family decided to wait until the following morning to contact their own General Practitioners. The independent Vascular Surgeon indicated that even if Kirsty had been reviewed and admitted to hospital, her underlying condition was so advanced that direct medical intervention is unlikely to have saved her. The following morning Kirsty's mother looked in on Kirsty, she appeared asleep and therefore did not disturb her. She contacted their GP practice and requested a domiciliary visit. A GP attended a short time later and identified that Kirsty had in fact died.
5	**CORONER'S 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. –

At the inquest, it was not possible to trace an appropriate individual from the now defunct NHS direct organisation to give evidence although an internal enquiry report which had been undertaken prior to NHS Direct Services being disbanded was presented, which identified a number of issues within the service provided.

It was not possible to identify whether the 111 service was ever made aware of this case and whether issues which were identified were addressed within the new 111 service.

In addition, earlier this year I noted that there was press coverage of a child's death where the 111 service was involved which appeared to have some striking similarities with issues which arose in this case. I understand that the matter was raised in parliament and that the Health Minister intimated that there would be some form of review of the service. I therefore consider it is important that the individual facts of this case should be raised and that I should raise my concerns.

I would also wish to stress that a representative from West Yorkshire Ambulance service gave evidence at the inquest confirming that a review which had been undertaken, which identified a number of issues, particularly with regard for the need for additional training of individual personnel, and that some changes had been made However, I continue to have a number of concerns with regard to the interaction between various agencies and their ability to gain access to recorded information.

My concerns are as follows.

1. There was no standard question asked at the beginning of the calls to identify whether the patient had previously contacted NHS Direct, or any other agency, with regard to the symptoms giving rise to the latest call.

2. Medical advisers in NHS Direct were not medically qualified, and emergency medical despatchers in West Yorkshire Ambulance service are not medically qualified. They were required to illicit details of the patient's symptoms, and proceed to identify the most significant symptom from the information gained to select the most appropriate questionnaire. I understand there are a significant number of questionnaires to select from. They repeatedly selected the incorrect questionnaire in Kirsty's case. This resulted in significantly different outcomes being followed. I am concerned that without medical training the likelihood of incorrect questionnaires being selected and as a consequence, incorrect pathways being followed will reoccur

3. Nurse Advisers within NHS Direct were reaching a diagnosis in Kirsty's case , without having the opportunity to undertake a face to face assessment, and there did not appear to be a lower threshold of recommending a face to face medical review

4.Within NHS direct there was a complete consistency of treating each call separately, there was no attempt to review details of earlier calls made.

	5. It was not possible at the inquest to review what details were recorded. I was concerned that details of earlier calls may not contain the conclusion and advice given to the patient. This information may be of significant assistance to ensure that if the patient calls again, appropriate care and advice is given. 6. The Nurse Adviser was able to override the recommendation of the questionnaire programme to downgrade the recommended advice outcome. This led to a tragic outcome in Kirsty's case. If Kirsty had attended accident and emergency at an early stage rather than being diagnosed with a bug and to self- care, the evidence indicated she would have lived. There were no safeguards put in place for this decision to be peer reviewed if a decision is taken to downgrade the recommended advice outcome. 7. All the different agencies operated in isolation, and despite computerised systems and phone facilities being available, there was no attempt to gain information from previous agencies which they had been involved 8. On the one occasion when NHS Direct advised Kirsty to attend her nearest accident and emergency service, no enquiry was made as to whether Kirsty had the means to attend.
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 18th August 2016. 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 and to the following Interested Persons [redacted] 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	**24th June** **Mary T Burke**