Regulation 28: Prevention of Future Deaths report

Collin Gary GRIFFITHS (died 08.04.18)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Managing Director** **MASTA Limited** **7th Floor** **City Exchange** **11 Albion Street** **Leeds LS1 5ES**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 25 April 2018, I commenced an investigation into the death Collin Gary Griffiths, aged 47 years. The investigation concluded at the end of the inquest on 30 August 2018. I recorded a medical cause of death of: 1a multi organ failure 1b yellow fever vaccine associated viscerotropic disease (YEL-AVD) 1c yellow fever vaccine 2 thymectomy in 2014 I made a determination as follows.

	On 23 March 2018, Collin Griffiths received the yellow fever vaccine that resulted in his death. The vaccine was contraindicated because he had previously undergone a thymectomy having developed a thymoma. The nurse who advised on the vaccine and administered the vaccination knew of the contraindication, but misheard when Mr Griffiths said that he'd had a thymoma.
4	**CIRCUMSTANCES OF THE DEATH** Mr Griffiths was told by his employer that he was being sent to Nigeria the following week and so did not have time to attend his general practitioner's surgery for his vaccinations. He and a colleague therefore attended a MASTA travel clinic. The nurse advising and administering the vaccinations was very well qualified and had a good understanding of the contraindications. However, when Mr Griffiths volunteered that he'd had a benign thymoma, the nurse misheard and thought he said that he'd had a benign spinal tumour. The first meant that a yellow fever vaccination was contraindicated, the second did not. The nurse asked whether Mr Griffiths had ever suffered certain medical conditions, but he ran off a list of these quickly and with a strong, Spanish accent. "Thymus" became "ty-mu" and was lost somewhere in the middle of the list.
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. 1. The recording of medical conditions was entirely dependent on the verbal communication, which in this instance was sub optimal. Would there be anything to stop MASTA handing out a tick box questionnaire (similar to the ones for blood donors) for patients to fill in while they are waiting to be seen? There seems to be a need for an added layer of security, rather than just relying on patients listening to a long list of conditions being read out.

	2. MASTA currently has no way of auditing whether the record a nurse makes is accurate. This could be assessed by questioning patients as they leave, or by sending in a patient specifically to test this anonymously.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you 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 5 November 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 following. • HHJ Mark Lucraft QC, the Chief Coroner of England & Wales • Care Quality Commission for England • Professor Dame Sally Davies, Chief Medical Officer for England • Medicines and Healthcare Products Regulatory Agency • [redacted], wife of Collin Griffiths 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 04.09.18