Blackpool Teaching Hospitals
NHS Foundation Trust

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[redacted]

5 July 2021

Mr Alan Anthony Wilson
Senior Coroner Blackpool & Fylde
PO Box 1066
Corporation Street
Blackpool
FY1 1GB

Your reference: Regulation 28 - Prevention of future deaths

Dear Mr Wilson

Re: Coral Amy O'Donnell (deceased) – Inquest concluded 29 April 2021

Further to your Regulation 28 Report to Prevent Future Deaths, dated 11 May 2021, in relation to the death of Coral Amy O'Donnell, who sadly died in the company of her family on the intensive care unit of Blackpool Victoria Hospital on 17 May 2019.

In my initial response letter, I explained that we would take actions to prevent a similar event from occurring.

Below, I detail my responses to the matters of concern you have raised with us and what action we have taken:

1) **That when evidence of Staphylococcus Aureus was identified the clinical and microbiology teams did not consider the possibility of Panton Valentine Leukocidin (PVL) Staphylococcus Aureus, despite Coral's history of skin infections and the severe pneumonia she presented with on admission in a previously young fit woman.**

Firstly, I must apologise that we failed to consider or identify the possibility of Panton Valentine Leukocidin (PVL) Staphylococcus Aureus for Coral. The details and the outcome have been discussed within the team and department and we are truly sorry for what happened. It is clear from the Serious Incident review that there was a general lack of awareness of this rare and serious strain of Staphylococcus Aureus within the Critical Care Consultant team. The report findings and the need to consider PVL has been shared with all the clinical staff within the department and also discussed at the Morbidity and Mortality

review meeting. The learning from this event will also be shared across the division and the wider organisation.

Following discussion with the Microbiology team, we have ensured that the Critical Care Consultant team consider PVL Staphylococcus Aureus in all cases where Staphylococcus Aureus is isolated, particularly where the clinical picture supports such a diagnosis. As part of our learning, we have had a very low index for initiating triple therapy where patients' presentation suggests PVL and this includes commencing Intravenous IgG in several patients. We are now confident that a similar situation in the Intensive Care Unit would not be repeated and that any cases discussed with microbiology where PVL was clinically likely, patients would be commenced on PVL cover from the start; we are now treating non-PVL MRSA/MSSA patients, as well as PVL patients, with extended PVL regimes.

2) **That there was a lack of awareness of PVL amongst senior clinicians, despite the fact that a senior Microbiologist from the hospital Trust confirmed that national guidance covering the treatment of such condition was in use at the Trust at the time, but none of the critical care team who gave evidence at the inquest seem to have been aware of that document. Although the court was told this has now been rectified there is a concern that some clinicians are unfamiliar with hospital protocols which may be relevant to their work.**

We acknowledge that there was a lack of awareness and knowledge with regards to PVL amongst the Critical Care Consultants, for which we apologise. As part of the discussions within the department, the Trust PVL policy has been shared with all the Critical Care Consultants. The importance of this infection has been discussed at the departmental meetings. We can assure you that all the Critical Care Consultants are familiar with the Trust PVL document and we will continue to raise awareness amongst our colleagues and at local induction.

3) **That communication between the critical care and microbiology teams was problematic and neither team considered PVL until there was established damage to her lungs identified on a chest x-ray. Senior clinicians had not mentioned a susceptibility to skin infections to the microbiologists which may have resulted in Coral receiving the correct treatment at an early stage of admission. The lack of communication between Microbiology and the clinical team appears to have in part been contributed to by a previous cessation of the thrice weekly joint microbiology and critical care ward rounds, which the court heard have not been re-instated.**

There are currently no joint ward rounds between the Critical Care Team and the Microbiology team, but there is better day to day communication and discussion at the Antimicrobial Stewardship Committee. At present, the day to day system is via telephone conversations with the Microbiology team, as and when required, plus the Critical Care Consultants will send e-referrals when they require Microbiology advice. However, we acknowledge that this falls short of what is ideal, and this needs to be improved. It has been highlighted that there is an objective to reinstate the three times a week joint ward round with the Consultant Microbiologist and Consultant Intensivist and the discussions to operationalise this are taking place. There are also imminent changes to the consultant staffing model that we believe will further improve matters.

4) **That the number of microbiologists at the time of Coral's admission was limited – a senior Microbiologist told the court her team ought to comprise six microbiologists, but were limited to a maximum of four at the time and that remains the case.**

The Trust is undertaking a staffing review, which takes into consideration the of role of infection specialists of various categories, not only microbiology trained medics, but also Microbiologists, Infectious Diseases Physicians, PhD grade Antibiotic Pharmacists and Clinical Scientists with or without FRCPAth.

5) **That there was a stark lack of awareness, noticeably amongst senior clinicians, about internal systems in place at the hospital Trust. The court heard about the Cyberlab system, and also a red flag system which the court was told a number of critical care clinicians had previously been unaware of. If clinicians have not received the necessary training in relation to such systems there is a risk they may not recognise potentially relevant information, placing patients at potential risk.**

We can only apologise that it has been highlighted that there was a lack of awareness with regards to the Cyberlab system and this is not acceptable. All Critical Care Consultants have now received the appropriate training relating to the 'red flag' system and how to access information. All new Consultants and junior doctors will receive Cyberlab training as part of their Trust induction. We will continue to raise awareness through education and training for all staff working on the unit to ensure that this does not recur.

I hope that the above responses provide you with the assurance that we have taken your concerns extremely seriously. We have identified a number of learning opportunities, which we believe will prevent a similar situation from happening again.

Yours sincerely,

[redacted]
Executive Medical Director