

An avoidable death of a three-year-old child from sepsis

A report by the Health Service Ombudsman for England on an investigation into a complaint from Mr and Mrs Morrish about The Cricketfield Surgery, NHS Direct, Devon Doctors Ltd, South Devon Healthcare NHS Foundation Trust and NHS Devon Plymouth and Torbay Cluster

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Foreword

We are publishing this report on an investigation into a complaint made by Mr and Mrs Morrish about the care and treatment provided to their son Sam, who died on 23 December 2010. Mr and Mrs Morrish also complained about the way in which the NHS investigated the circumstances surrounding Sam’s death.

Sam Morrish and his family came into contact with The Cricketfield Surgery, Devon Doctors Ltd, NHS Direct and South Devon Healthcare NHS Foundation Trust in the days before he died. We have found that each of these organisations failed in some way.

Our report on sepsis, Time to Act, highlighted the lack of action being taken to save the lives of people with sepsis. Sadly, this case demonstrates once again that a failure to rapidly diagnose and treat sepsis can have tragic consequences.

We have found that had Sam received appropriate care and treatment, he would have survived, and that a lack of appropriate and timely bereavement support compounded the distress caused to his family as a result of the failures in care. We have also found failures in the way that the NHS investigated the events that took place, and that this caused the family a further injustice.

We have recommended that the NHS organisations involved write to Mr and Mrs Morrish to acknowledge and apologise for the service failure and maladministration identified in this report and the injustice they have suffered as a consequence.

We have also recommended that the NHS make a payment of £20,000 to Mr and Mrs Morrish. This should be made in recognition of the opportunities the NHS missed to save Sam’s life, the injustice that

this knowledge will continue to cause Mr and Mrs Morrish, and the opportunities that the NHS missed to properly investigate the circumstances surrounding Sam’s death.

In addition, we have also recommended that, where we have found service failure on the part of individual clinicians, those clinicians meet their supervisors to discuss the findings of this complaint.

We have also made recommendations in order to ensure that the learning from this case is taken forward by the wider NHS. These include that:

- The Cricketfield Surgery, working with South Devon and Torbay Clinical Commissioning Group (CCG) and Northern, Eastern and Western Devon CCG, ensures that guidance is in place to assist reception staff in directing patients through the system of telephone triage. This should be published so that patients and staff know what to expect and what is expected of them.
- NHS England should review the guidelines in place for contingency plans in relation to out-of-hours services and ensure that it is a specific requirement that NHS organisations demonstrate that their contingency plans are regularly tested and their strengths and weaknesses are identified and addressed.
- South Devon and Torbay CCG, Northern, Eastern and Western Devon CCG and South Devon Healthcare NHS Foundation Trust should put in place appropriate and clear processes for providing bereavement services to families in similar situations to that of Mr and Mrs Morrish, including providing training for staff so that they have the necessary knowledge and expertise to provide the services that are required. The processes should

be published so that families like the Morrishes can easily access the support they require in such difficult circumstances.

- South Devon and Torbay CCG and Northern, Eastern and Western Devon CCG identify a methodology for conducting root cause analysis investigations when serious incidents have occurred and ensure that, within three months, there are people at the organisations trained in that methodology and using it effectively when investigating serious incidents.

Finally, we think this case reinforces the need for independent investigations of complaints about serious incidents using root cause analysis and the science of human factors. We expect service providers to adopt this approach to help them understand why mistakes happen and help improve services for everyone.

We recognise that our investigation has taken too long and that this has contributed to the family’s ongoing distress. We have apologised to the family for this. We would like to thank Mr and Mrs Morrish for their valuable insight into the methodology we used to investigate their complaint. We are currently developing that methodology and we will be letting them know how we have improved our service.

Dame Julie Mellor, DBE
Health Service Ombudsman

June 2014

Introduction

1. Mr and Mrs Morrish complained to us about the care and treatment given to their three-year-old son, Sam, who died on 23 December 2010 following a short illness. In the days before his death, Sam was treated by two GPs at The Cricketfield Surgery (the Surgery). Mr and Mrs Morrish also sought advice from NHS Direct, Devon Doctors Ltd, a local out-of-hours GP service, before Sam was taken to Torbay Hospital, which is part of South Devon Healthcare NHS Foundation Trust (the Trust), as an emergency. We have found that every organisation that provided care to Sam failed in some way. We have also found that had Sam received appropriate care and treatment, he would have survived. In this report, we have set out our findings in detail, along with the recommendations we have made in order to ensure that the lessons of this tragic case are taken forward by the wider NHS to avoid this happening again.

A summary of what happened

2. Mr and Mrs Morrish's son, Sam, was three years old when he became unwell during a flu epidemic in December 2010. After being ill for around a week (he had flu symptoms, stomach pain, and had vomited) he was seen by a GP at the Surgery (the First GP) on 21 December. The First GP prescribed antibiotics just in case an infection developed and sent Sam home. Sam felt worse the next day so Mrs Morrish called the Surgery in the morning to ask for advice. A nurse practitioner rang Mrs Morrish at 1.50pm, and after discussing Sam's condition with her, told her another GP (the Second GP) would contact her. The Second GP called Mrs Morrish at about 2pm and organised an appointment for Sam at 4.10pm that afternoon. The Second GP assessed Sam at about 4.30pm, gave him cough syrup, and sent him home.

3. Later that evening, Sam vomited again and, after realising the Surgery was closed, Mrs Morrish called NHS Direct. A nurse adviser (a qualified nurse) assessed Sam's condition. She referred his care to Devon Doctors Ltd at 6.48pm. A GP from Devon Doctors Ltd attempted to call Mrs Morrish at 7.12pm, but there was no answer. Mrs Morrish said that she remembers her telephone ringing, but because she was attending to her other son, she was unable to answer the call in time. When she dialled 1471 to find out who had called, the number had been withheld so she did not know who had tried to contact her.

4. Mrs Morrish called Devon Doctors Ltd a couple of hours later and she was told to take Sam to their Newton Abbott Treatment Centre (the Treatment Centre) so he could be seen by a GP. When she arrived at the Treatment Centre, Mrs Morrish had to wait to see a GP. Once a GP saw Sam, he immediately arranged for him to be admitted to Torbay Hospital (part of the Trust) and he arrived at around 10.30pm. Doctors in A&E diagnosed Sam with pneumonia (swelling of the tissue in one or both lungs, usually caused by an infection) and prescribed antibiotics. Doctors also thought that Sam might have sepsis.¹ Sam was subsequently transferred to a paediatric high dependency unit.² He was given the prescribed antibiotics at 1.30am. In the early hours of 23 December, Sam's condition deteriorated, and he died shortly after 5am.

5. After Sam's death, Mr and Mrs Morrish contacted both the Surgery and a paediatric consultant at the Trust in an attempt to access counselling for themselves and for their other son. They did not receive formal support for a number of months.

6. Mr and Mrs Morrish also met GPs at the Surgery, and a paediatric consultant at the Trust, to try and understand why their son died. At the same time, NHS Devon Plymouth and Torbay Cluster (the PCT)³ began to investigate the cause of Sam's death, and produced a root cause analysis investigation report (a copy of that report is at Annex E). Mr and Mrs Morrish were unhappy with the PCT's investigation. The PCT subsequently commissioned an independent investigation, chaired by the chief executive of another NHS hospital trust. Mr and Mrs Morrish did not consider that the second investigation addressed their concerns and approached us with their complaint.

¹ Sepsis is defined as an infection in which the body's immune system goes into overdrive, setting off a series of reactions that can lead to widespread inflammation (swelling) and blood clotting. Severe sepsis occurs when the body's response to infection starts to interfere with the function of vital organs (for example, the lungs, heart or kidney). Septic shock is a potentially lethal drop in blood pressure (due to bacteria in the blood), which prevents blood being delivered to the organs. It can lead to multiple organ failure.

² This is the first record of doctors having considered transferring Sam to the high dependency unit. The high dependency unit contains two beds and is part of the Trust's children's ward.

³ Primary care trusts, such as the PCT, ceased to exist on 31 March 2013. Their commissioning function has been replaced by clinical commissioning groups (CCGs) and the NHS Commissioning Board (now NHS England). NHS Devon's local commissioning functions are now carried out by South Devon and Torbay CCG (lead commissioners for services provided by South Devon Healthcare NHS Foundation Trust) and by Northern, Eastern and Western Devon CCG. NHS England has taken on responsibility for legacy issues arising from NHS Devon's actions.

The complaint

7. Mr and Mrs Morrish complained that:

- the Surgery did not provide appropriate care and treatment for Sam, there was a lack of suitable bereavement support, and it did not adequately investigate what had happened
- NHS Direct did not appropriately assess Sam or adequately investigate what had happened
- Devon Doctors Ltd did not provide an appropriate or timely assessment for Sam, and did not adequately investigate what had happened
- the Trust did not provide appropriate care and treatment for Sam, or bereavement support for his family, and did not adequately investigate their complaint
- the PCT did not carry out adequate and timely reviews of their complaint.

8. Mr and Mrs Morrish believe that if their son had received appropriate treatment he might still be alive. This causes them significant and ongoing distress. Mr and Mrs Morrish also say that the lack of bereavement support left their family to deal with their son's death and the circumstances surrounding it without help, which made the situation worse for them, and caused further distress.

9. Mr and Mrs Morrish say that the protracted complaint handling processes they had to navigate left them without a comprehensive understanding of what might have gone wrong, and placed the onus on them to drive the process forward. Mr and Mrs Morrish told us that they felt the NHS saw them as a problem that had to be contained and managed. They said

they had lost all faith in the NHS and were left feeling that it would prefer to look after its own interests rather than openly, transparently and honestly respond to their complaints.

10. Mr and Mrs Morrish seek a number of outcomes from our investigation, including:

- the organisations to acknowledge and learn from what went wrong in order to ensure that the same mistakes are not repeated
- an apology from those organisations that failed Sam and an opportunity to discuss the steps each organisation has taken, or will take, to improve services and prevent any failings happening again
- increased local and national awareness of sepsis
- easier access to flu vaccinations for children
- an independent investigation to establish what happened and the cumulative effects of any failings
- individuals and NHS organisations to be held accountable for any failings
- the Surgery and the Trust to improve their bereavement services
- compensation for the distress and upset their family has suffered as a consequence of any failings.

Our decision

11. We uphold Mr and Mrs Morrish's complaints. We have found service failure in the care and treatment given to Sam by the Surgery, NHS Direct, Devon Doctors Ltd and the Trust. Each of these organisations failed to provide appropriate care and treatment when Sam and his family came into contact with them. This service failure led the family to suffer the most significant of injustices. Were it not for the errors in the care and treatment provided to Sam, he would have survived his illness.

12. We have also found maladministration in the way that each of the organisations involved investigated the complaints made to them about the care and treatment they provided to Sam. The PCT, whose role it was to investigate events in a holistic manner, also failed to properly consider the complaints made about Sam's death. These failures further exacerbated the distress of the family at what was already a very upsetting time.

13. We have set out our detailed findings in respect of each organisation below.

Our role

14. Our role⁴ is to consider complaints about the NHS in England. We start by considering whether there is evidence that there has been maladministration by an NHS organisation, a failure in a service it provided or a failure to provide a service it was empowered to provide. If so, we consider whether that led to an injustice or hardship.⁵

How we consider complaints

15. When considering a complaint, we begin by comparing what happened with what should have happened. We consider the general principles of good administration that we think all organisations should follow. We also consider the relevant law and policies that the organisation should have followed at the time.
16. If the organisation's actions, or lack of them, were not in line with what they should have been doing, we decide whether that was serious enough to be maladministration or service failure.
17. We then consider whether maladministration or service failure has led to an injustice or hardship. If we find an injustice that has not been put right, we will recommend action. Our recommendations might include asking the organisation to apologise or to pay for any financial loss, inconvenience or worry caused. We might also recommend that the organisation take action to stop the same mistakes happening again.
18. When we investigated this complaint, we looked at the relevant evidence for the case, including Sam's clinical records and the investigations into the events that led to his death. We also met Mr and Mrs Morrish, and have taken advice from seven of our clinical advisers. Our clinical advisers are experts in their field. In their role as advisers, they are completely independent of the NHS. We have taken advice from a general practitioner (the GP Adviser), a registered nurse with experience of NHS Direct (the NHS Direct Adviser), a general practitioner who works in out-of-hours GP care (the Out-of-Hours Adviser), a paediatric nurse (the Paediatric Nurse Adviser), a paediatric intensive care unit consultant (the Paediatric Intensive Care Unit Adviser), a paediatric consultant (the Paediatric Consultant Adviser), and a consultant in infectious diseases (the Infectious Diseases Consultant Adviser).
19. The clinical advice reports we received are presented in Annex D; we shared this advice with the organisations responsible for Sam's care.

Key events

20. There is a detailed chronology of the key events in Annex A.

Our findings

21. Mr and Mrs Morrish complained about the clinical care and treatment provided by the Surgery, NHS Direct, Devon Doctors Ltd and the Trust. We will address each area of concern in turn.

Mr and Mrs Morrish's complaints about the Surgery

22. The guidelines that are relevant to Mr and Mrs Morrish's complaints about the Surgery are *Feverish illness in children guideline 47* (Feverish Illness in Children) from the National Institute for Health and Care Excellence (NICE), and the General Medical Council's guidance *Good Medical Practice* (Good Medical Practice). We have taken these guidelines into account, as well as advice from our GP Adviser.

The First GP

23. Feverish illness in children states that doctors should '*measure and record temperature, heart rate, respiratory rate and capillary refill time as part of the routine assessment of a child with a fever*'. It also states that a raised heart rate can be a sign of serious illness, particularly septic shock, and that antibiotics should not be prescribed without identifying the apparent source of infection.
24. The First GP said it was his normal practice to assess dehydration, breathing rate and temperature. When he saw Sam on 21 December, he noted that Sam had had a high temperature for a week, and had a cough, a rash and had been vomiting. The First GP considered that Sam had a '*flu-like illness*' and sent him home. He prescribed antibiotics and, although he did not record it in his notes, he says that he told Mrs Morrish to give Sam the antibiotics if his condition worsened.
25. At the time he saw the First GP, Sam had one clear amber feature of the Feverish Illness in Children guideline's traffic light system - he had had a fever for at least five days. However, because the First GP did not measure Sam's breathing rate, we cannot say whether at that point Sam's condition included any of the red features of the traffic light system. Because of this, we are unable to say whether Sam should have been referred urgently to a paediatric specialist. An urgent referral would have been the appropriate next step, if Sam had displayed any red features.
26. Although the First GP said it was his normal practice to assess dehydration, breathing rate and temperature, there is no evidence that he did this when he saw Sam on 21 December. The First GP has also acknowledged that he failed to formally assess and record Sam's heart rate. Although the First GP has told us he made a '*definitive diagnosis*', given the inadequacy of the assessment, we cannot agree. On that basis, his decision to prescribe Sam antibiotics was not in line with Feverish Illness in Children. Overall, we have found that when the First GP assessed Sam on 21 December, he failed to follow established good practice and this was service failure.
27. Based on the assessment that was completed, Sam had one amber feature of the traffic light system. According to Feverish Illness in Children, the First GP should have ensured that a '*safety net*' was in place. This could have involved a number of actions: telling Mrs Morrish what '*warning signs*' to look out for, such as specific symptoms, for example, being lethargic and pale, how to access further healthcare, arranging a follow-up appointment, or referring Sam to a paediatric specialist for further assessment.

⁴ Our role is formally set out in the *Health Service Commissioners Act 1993*.

⁵ The *Health Service Commissioners Act 1993* allows organisations to refer themselves to the Ombudsman if a person has sustained injustice or hardship in consequence of a failure in service or maladministration.

28. The First GP's records of the assessment are poor and on their own do not give clear evidence that he ensured an adequate 'safety net' was in place. However, Mrs Morrish has told us that the First GP told her to bring Sam back to the Surgery if he got worse. On that basis, we believe the First GP provided an appropriate 'safety net'. Therefore, his actions in relation to this aspect of the care provided were not so serious as to constitute service failure.

Telephone triage and the Second GP

29. When Mrs Morrish telephoned the Surgery on 22 December at 10.45am, reception staff placed her call on a list of patients for the GPs to call back. The Surgery has confirmed that it does not expect reception staff to be involved in prioritising calls because they are not medically trained. However, our GP Adviser has said that the Surgery should have given reception staff guidance in order to help them assess the priority level of each call received. The fact that no guidance was in place was a service failure. We note that since these events, the Surgery has installed a new telephone triage system that includes reception staff being trained in how to direct patients through the system.

30. Mrs Morrish spoke to the nurse practitioner at 1.50pm. The nurse practitioner recorded that Sam was worse, lacked energy, was lethargic, and had not improved after he was given Calpol and ibuprofen. This information was passed to the Second GP who then spoke to Mrs Morrish at approximately 2pm. The Second GP told us that after speaking to Mrs Morrish about Sam's condition, he felt that the appointment he made (for 4.10pm) was at an appropriate time. He said this took into account 'the history he had obtained', the time it would take Mrs Morrish to get to the Surgery, other

patients he still had to contact, and those he had arranged to see.

31. We do not agree with the Second GP's assessment of his actions. We believe that, at this point, the Second GP should have been aware that Sam's condition was worsening. This is because the information in Sam's medical records noted that the day before, the First GP had identified that Sam had had a fever for a week (an amber feature in the traffic light system). Furthermore, our GP Adviser has noted that the description of Sam as lethargic should have prompted the Second GP to note that Sam now had a symptom under the red features of the traffic light system. Our GP Adviser added that the Second GP should have asked Mrs Morrish about Sam's urine output. Had he done so, and Mrs Morrish had said that Sam's nappy was dry, she should have been told to bring Sam to the Surgery for immediate assessment. The Second GP's actions in assessing Sam following this telephone call amount to service failure.

32. When the Second GP saw Sam, he should have adequately assessed Sam in accordance with *Feverish illness in children*. This would have involved assessing and recording his heart rate, respiratory rate, hydration rate and his temperature.

33. The Second GP recorded that Sam was awake and communicating, that his hydration and respiratory rate were 'OK', and his chest 'clear'. He did not record what the specific measurements were. Mr and Mrs Morrish told us that Sam's temperature was lower than it was the day before, but his condition was worse. They said that the Second GP took Sam's temperature during the consultation, although the reading is not recorded in the notes. There is also no evidence from the notes that he measured Sam's heart rate.

34. In response to our enquiries, the Second GP has accepted he did not document Sam's heart rate but he noted that the traffic light system does not include the need to record the heart rate. While it is correct that the traffic light system does not include a reference or requirement to measure the heart rate, *Feverish Illness in Children* specifically states that the heart rate should be measured and recorded. The Second GP says he would have asked about Sam's fluid intake (which he considered was 'plenty'), and checked capillary refill time⁶ and so assessed whether Sam was dehydrated.

35. We acknowledge that Sam was awake during the consultation. However, we must also take into account the fact that the Second GP was aware of Sam's very recent history of lethargy, his lack of energy (he was 'sleeping a lot') and Mrs Morrish's concern that her son's condition was getting worse. Having taken account of the GP Adviser's comments, we believe that the Second GP should have paid more attention to Mrs Morrish's concerns and Sam's history. We also cannot ignore the fact that reduced urine output is a specific amber feature of the traffic light system. The Second GP should have asked about Sam's urine output. It is highly likely that, had he checked this and had Sam's urine output been noted at the appointment, the Second GP would have recognised that Sam now had a red and an amber feature of the traffic light system and so was deteriorating and in need of urgent treatment.

36. The Paediatric Adviser commented that, because the chest X-ray (on admission to hospital) showed that Sam had extensive

consolidation in his right lung, he would, on the balance of probabilities, have had some abnormal chest signs when the Second GP saw him. Our GP Adviser agreed that it is likely there would have been chest sounds during the consultation with the Second GP. We cannot say why the Second GP noted that Sam's chest was 'clear' when, in all likelihood it was not. Our GP Adviser commented that it is possible that the Second GP did not listen to Sam's chest for long enough, however, she also said that it is possible that normal chest sounds from the non-consolidated lung could have been transmitted to the congested right lung. We simply cannot know what the Second GP heard when he listened to Sam's chest.

37. Overall, we find that the Second GP's assessment of Sam was inadequate and constituted service failure.

38. We have already noted that *Feverish Illness in Children* states that if a patient has any amber features of the traffic light system, doctors should ensure a 'safety net' is in place. The Second GP acknowledged that Sam continued to have one amber feature of the traffic light system (prolonged fever). If he had checked Sam's urinary output, the Second GP would have known he had two features of the traffic light system. However, there is no evidence that he ensured a 'safety net' was in place and Mrs Morrish told us that when she left the appointment with the Second GP she did not know what to do if Sam's condition became worse. We therefore conclude that an adequate 'safety net' was not in place.

⁶ A capillary refill test measures the time taken to refill the very small blood vessels in the body. It is used to measure whether someone is dehydrated. A refill time of less than three seconds is considered normal, whereas a time greater than this indicates increasing degrees of dehydration.

39. In summary, both the First GP and the Second GP failed to adequately assess Sam. The Second GP also failed to ensure an adequate safety net was in place as required. It is also worth noting that the only reason we have found that the First GP ensured an appropriate ‘safety net’ was in place is because Mrs Morrish’s evidence supports this. We think it is important to say that this does not excuse the poor record keeping of the First GP. Neither doctor took proper account of established good practice as set out in Good Medical Practice and Feverish Illness in Children. Furthermore, the Surgery did not have adequate systems in place to enable the receptionist to prioritise calls to its service as it should have had. Overall, we find that the standard of care and treatment the Surgery provided for Sam constituted service failure.

Mr and Mrs Morrish’s complaint about NHS Direct

40. The guidelines that are relevant to Mr and Mrs Morrish’s complaints about NHS Direct are set out in the Nursing and Midwifery Council (NMC) guidance. We have taken those guidelines into account when coming to our conclusions, as well as advice taken from a registered nurse with experience of NHS Direct (our NHS Direct Adviser).

The conversation with the health adviser

41. The health adviser took down Mrs Morrish’s details and the reason for her call. She noted that Sam had vomited and that there were ‘lots of dark brown blobs in it’. Our NHS Direct Adviser has commented that the health adviser should have asked Mrs Morrish if she had called the service before, but she did not.

Despite this, there is no evidence that this impacted the ‘efficiency or safety’ of the call and the actions of the health adviser overall were appropriate.

The conversation with the NHS Direct nurse adviser

42. There are two aspects of the conversation with the NHS Direct nurse adviser to consider. The first is whether the NHS Direct nurse adviser acted appropriately when she asked Mrs Morrish about Sam’s condition and recorded her answers. The second is whether, at the end of the conversation, she adequately assessed the situation based on the information she gathered during the call and then took the necessary steps to manage that by choosing the appropriate course of action.
43. When the call was transferred to her, the NHS Direct nurse adviser chose the most appropriate algorithm for Sam’s symptoms (*Vomiting Toddler – Age 1 to 4 years*). However, our NHS Direct Adviser has commented that during the call, the NHS Direct nurse adviser recorded definitive answers to questions she had not fully explored, for example, when asking the question about whether or not Sam had a distinctive rash. Our NHS Direct Adviser has also noted that the NHS Direct nurse adviser did not ask all of the appropriate questions, for example, whether Sam could be roused when Mrs Morrish told her that he was asleep.
44. From what follows, it seems clear that the most important question the NHS Direct nurse adviser asked was whether Sam had blood in his vomit. Mrs Morrish clearly told her that Sam’s vomit contained brown lumps and ‘glutinous’ strands. Our NHS Direct Adviser said that the NHS Direct nurse adviser should have recognised that the symptoms Mrs Morrish described

indicated that Sam’s vomit might contain blood. Therefore, the answer to this question should have been recorded as ‘yes’. However, the NHS nurse adviser recorded the answer ‘no’. We cannot say why the NHS Direct nurse adviser recorded the answer ‘no’. However, we have seen no information to persuade us there was any reason to doubt that Mrs Morrish’s description should have prompted the NHS Direct nurse adviser to answer ‘yes’. We consider that this error amounts to service failure.

45. As a result of the call, the NHS Direct nurse adviser referred Sam, on a non-urgent basis, to Devon Doctors Ltd. This meant Mrs Morrish should have been contacted within six hours. However, had the call gone as it should have done, and had the NHS Direct nurse adviser answered ‘yes’ to the question of blood in Sam’s vomit, the algorithm would have directed the NHS Direct nurse adviser to tell Mrs Morrish to take Sam to A&E as soon as possible.
46. As part of the call, the NHS Direct nurse adviser should have made her own judgment about how quickly Sam should be assessed, and who should do that assessment. In practice, this would have meant considering whether the conversation indicated that a more urgent course of action was necessary than that which was indicated by the algorithm. For example, what facilities an out-of-hours GP provider had available to them, and whether they would be able to carry out necessary investigations and provide appropriate treatment.
47. Even allowing for the NHS Direct nurse adviser’s failure to answer ‘yes’ to the question regarding blood in Sam’s vomit, she knew from the call that Sam had not passed urine since mid-morning, he had

fast and shallow breathing, and he had a fever. Our NHS Direct Adviser has noted that, regardless of the errors made by the NHS Direct nurse adviser in her assessment, it should have been clear that Sam required more in-depth investigations to establish the cause of his symptoms. Our NHS Direct Adviser has also said that the NHS Direct nurse adviser should have realised that it was likely Sam needed intravenous fluids, because the information given by Mrs Morrish suggested he was dehydrated. We have seen no evidence that the NHS Direct nurse adviser took any of these considerations into account or applied any critical thinking or reasoning when she chose the pathway of making a non-urgent referral to an out-of-hours GP service. This was not in line with established good practice or NMC guidance and constituted service failure.

Devon Doctors Ltd

48. The guidelines that are relevant to Mr and Mrs Morrish’s complaints about Devon Doctors Ltd are the *National Quality Requirements in the Delivery of Out-Of-Hours Services* (the Quality Requirements). We have considered the Quality Requirements when coming to our conclusions, and have also taken advice from a general practitioner who works in out-of-hours GP care (the Out-of-Hours Adviser).

How Devon Doctors Ltd dealt with NHS Direct’s referral

49. Devon Doctors Ltd received details of the NHS Direct nurse adviser’s assessment at 6.44pm. In line with the Quality Requirements, and given that Devon Doctors Ltd had been told that Sam’s condition was non-urgent, they should have begun a definitive assessment within 60 minutes, so by 7.44pm. Records indicate

that a GP attempted to call Mrs Morrish at 7.12pm; however, the call was not answered. A doctor did not try again until 9.19pm because the service was extremely busy and NHS Direct had said that Sam's condition was not urgent. Devon Doctors Ltd should have tried to contact Mrs Morrish again after they were unable to speak to her when they tried at 7.12pm. If they had remained unsuccessful, they should have referred the call back to the call centre to make further efforts to reach the family.

50. Devon Doctors Ltd have said that they were busy that evening and that their clinicians have autonomy in prioritising call backs to patients. However, we consider that support staff should have recognised that Devon Doctors Ltd's actions in relation to Mrs Morrish's call had significantly breached the 60-minute target set out in the Quality Requirements. Support staff should have taken steps to highlight this to the clinicians. We note that Devon Doctors Ltd placed responsibility for calling patients on the clinicians, however, we consider that support staff should also have been involved in reviewing the calls to make sure they were dealt with promptly. Devon Doctors Ltd's actions in relation to this aspect of the complaint constituted service failure.

51. When Mrs Morrish rang Devon Doctors Ltd at 8.52pm, her call was not logged on the system, and there is no evidence that the call handler noted that the 60-minute target for ensuring a definitive assessment had been breached. The call handler contacted the Treatment Centre to tell them Mrs Morrish had called. Had the call handler noted that the target had been breached, it would have been appropriate for them to raise this with a GP. Our Out-of-Hours Adviser has said that at the very least, common sense should have

dictated that the call handler should alert the doctors to the breach. Further, when Mrs Morrish spoke again to Devon Doctors Ltd at 9.08pm, the call handler should also have informed a GP that Mrs Morrish had told them that Sam had vomited black liquid, but they did not. Our Out-of-Hours Adviser has noted that although it is not reasonable to expect non-clinical staff to make clinical judgments, it is reasonable to expect organisations like Devon Doctors Ltd to have policies in place so that non-clinical staff can confidently escalate cases that may concern them. It does not appear that such guidance was in place at Devon Doctors Ltd. This was service failure.

52. Turning to the decision to advise Mrs Morrish to take Sam to the Treatment Centre, our Out-of-Hours Adviser has noted that the advice given about where to take Sam at that point should have been made by a clinician. The fact that it was not means that the decision was not based on all of the relevant considerations, given the absence of clinical input at this stage. This was service failure.

53. Devon Doctors Ltd have acknowledged that Sam arrived at the Treatment Centre without a definitive assessment, and that a life-threatening condition had not been recognised earlier. We have found that Devon Doctors Ltd failed to definitively assess Sam within 60 minutes as they were required to do. We have also found that Devon Doctors Ltd sent Sam to the Treatment Centre without taking account of all relevant considerations or seeking a clinical view. Further, Devon Doctors Ltd failed to take appropriate action to identify and respond to a call that had significantly breached the relevant targets. Overall, we find that their actions fell well below the applicable standards and constituted service failure.

54. Devon Doctors Ltd have stated that their service was very busy because of a flu epidemic and the weather conditions, but that they had a full complement of staff. The Quality Requirements make it clear that out-of-hours services should have '*robust contingency policies for those circumstances in which they may be unable to meet unexpected demand*'. We note that Devon Doctors Ltd had brought in additional staff to cope with the predicted demand in service because of the flu epidemic and adverse weather. We also note that our Out-of-Hours Adviser has commented that, under the Quality Requirements, she considered that Devon Doctors Ltd had a '*robust contingency plan*' in place. While Devon Doctors Ltd may have had what appeared to be a '*robust contingency plan*' in place, we cannot agree that it was implemented appropriately, based on these events and the quality of the treatment Sam and his family received.

The Treatment Centre

55. When Mrs Morrish arrived at the Treatment Centre at 9.38pm, she believed that Sam would be seen immediately. However, there is no evidence that the call handler passed on information about the urgency of Sam's condition. Instead of being seen and assessed as a priority, Mrs Morrish had to attract the attention of a passing nurse for anyone to examine her son. Sam was not assessed until a GP saw him at 10.01pm, at which point it was identified that Sam had a life-threatening condition and staff called an ambulance. We find it wholly unacceptable that Devon Doctors Ltd put Mrs Morrish in this position. She had to 'flag' down a passing nurse in order to get her son the urgent treatment he so desperately needed. The actions of staff at Devon Doctors Ltd in

respect of the above events constituted significant service failure.

The Trust

56. The guidelines that are relevant to Mr and Mrs Morrish's complaints about the Trust are set out in Good Medical Practice, the Sepsis Guidelines, and the PICS Guidelines (Annex C, paragraph 16). Staff should also have followed the Trust's own policy and guidance, in this case, the Escalation Plan. We have taken these guidelines into account when coming to our conclusions, as well as advice taken from a paediatric nurse (the Paediatric Nurse Adviser), a paediatric intensive care unit consultant (the Paediatric Intensive Care Unit Adviser), a paediatric consultant (the Paediatric Consultant Adviser) and a consultant in infectious diseases (the Infectious Diseases Consultant Adviser).

Care and treatment in A&E

57. When Sam was first admitted to A&E at approximately 10.30pm, doctors appropriately assessed and examined him, and noted his abnormal physiological observations and low urinary output as well as his recent medical history. In view of the clinical advice we have received, it is clear that Sam had signs and symptoms of sepsis when he was admitted to hospital. The paediatric consultant has said that when he first discussed Sam's care with the paediatric registrar, he thought Sam had sepsis secondary to a lung infection. The Sepsis Guidelines state that until the organism causing the infection is identified, prompt antibiotic treatment, using broad-spectrum antibiotics, should be given. In Sam's case, the doctors prescribed a broad-spectrum antibiotic within an hour of his arrival at hospital. This was an appropriate course of treatment.

58. During Sam's admission, he was given a number of fluid boluses to treat and rehydrate him. He was given the first fluid bolus at 11.15pm. The Paediatric Nurse Adviser said that nurses should have closely monitored Sam's condition, and accurately recorded his paediatric early warning score more often than they did to see whether the fluid boluses had worked. While nurses recorded Sam's observations at 11.20pm, they did not record his paediatric early warning score. Furthermore, when nurses checked Sam's observations again an hour later (at 12.20am), the observations were incomplete (they did not take Sam's temperature or blood pressure), and they did not record his paediatric early warning score. Taking into account the Paediatric Nurse Adviser's comments, we consider the frequency of monitoring did not reflect established good practice and was service failure.

59. The PICS Guidelines state that patients should be referred to a paediatric intensive care unit if they have '*symptoms or evidence of shock, respiratory distress or respiratory depressions*'. On admission to A&E, Sam was seriously ill and showed early signs of shock. Taking account of the Infectious Diseases Consultant Adviser's comments, by 11.30pm, and certainly by 12.20pm, Sam's illness was such that doctors should have sought advice on how best to treat and manage his condition with the paediatric intensive care unit in Bristol. They did not and this constituted service failure.

60. We have considered the comments of the paediatric consultant regarding the reasons Sam was transferred to the high dependency unit. We have also taken account of the advice of our Paediatric Adviser. We have found that, even though the decision made to transfer Sam to the

high dependency unit was appropriate, based on the information it had, the fact that the Trust did not seek the necessary advice meant that the information used to inform that decision was seriously flawed.

61. It was not until 1.30am, when Sam had been transferred to the high dependency unit, that a nurse administered the antibiotics he had been prescribed over two and a half hours earlier when he was first assessed in A&E.

62. A number of differing explanations for the delay in Sam getting the antibiotics he needed have been given as a result of the investigations that took place after his death. A version of the root cause analysis report said that it was due to nurses' education and training. The version of the report that was sent to Mr and Mrs Morrish on 14 June said that it was due to '*a lack of a paediatric nurse overnight in A&E, combined with the reluctance of A&E staff to calculate doses for children and administer them*'. The paediatric consultant said it was because staff prioritised getting Sam transferred to the high dependency unit.

63. The Trust has subsequently told Mr and Mrs Morrish that the prescribed antibiotics were not given to Sam because the prescription was not written in the correct place, and that this was only discovered when Sam was being prepared for transfer to the high dependency unit. We note that the antibiotics were prescribed between 10.30pm and 11pm, the first recorded discussion about transferring Sam to the high dependency unit was at 12.15am (Annex A, paragraph 27) and he arrived in the high dependency unit at 12.45am. If this is indeed the reason why Sam did not receive the antibiotics, it is wholly unacceptable, because the antibiotics

could easily have been administered while he waited to be transferred. Of course, equally, if, as the Trust has subsequently said, the delay was due to an administrative error, such an error is also wholly unacceptable.

64. It is clear that there was a significant delay in Sam receiving the antibiotic treatment he so desperately needed. We have seen a number of possible explanations that might indicate the reason for the delay that occurred. Although we cannot be sure at this stage precisely what happened, the explanations we have seen suggest a number of problems at the Trust that might have contributed to the poor care Sam received.

Care and treatment in the high dependency unit

65. Nurses took Sam's paediatric early warning score twice after he was transferred to the high dependency unit. At 1am, they recorded that Sam had a paediatric early warning score of four, and in accordance with the Trust's Escalation Policy, they asked for a doctor to review Sam within 30 minutes. A paediatric registrar saw Sam within 45 minutes. 15 minutes later, at 2am, Sam's paediatric early warning score was five. The Escalation Policy states that when a score of five is calculated, the patient should be reviewed by a paediatric consultant, an anaesthetist and a critical care team. This policy was not followed in Sam's case and that is unacceptable. Sam was reviewed by a junior doctor from the intensive care unit at 2.10am. A consultant anaesthetist saw Sam at 3am. There is no evidence that Sam was seen by the paediatric consultant or the critical care team during this period (the paediatric consultant was at home at this time). The fact that Trust staff failed to act in

accordance with its own Escalation Policy is unacceptable and clear service failure.

66. We have obtained advice from our Paediatric Intensive Care Unit Adviser in order to establish whether more should have been done by seeking advice from the paediatric intensive care unit in Bristol. Our Paediatric Intensive Care Unit Adviser has said that such advice should be sought when a senior clinician is concerned that a child is deteriorating and not responding to treatment. We think there is sufficient evidence to suggest that this was the case at 1am. Had advice been taken at that stage, our Paediatric Intensive Care Unit Adviser has said that the Trust would have been advised to give Sam more aggressive fluid therapy. Although the paediatric registrar spoke to the paediatric intensive care unit in Bristol, this did not happen until approximately 3.30am. This was too late. The paediatric intensive care unit was not involved in Sam's care when it should have been, so Sam was not referred to another practitioner when it was in his best interests. This constituted service failure.

Discussions with the coroner's office

67. We are satisfied with the explanation the paediatric consultant gave for referring Sam's death to the coroner's office. We consider this explanation is reasonable and reflected established good practice. However, before speaking to the coroner's office, the paediatric consultant had not read Sam's medical records. While we recognise that the paediatric consultant had to ensure that the coroner was made aware of Sam's death as soon as possible, he also had a responsibility to ensure that he gave the coroner all the relevant information. The fact that he did not do this demonstrates poor practice.

The decision for the paediatric consultant to go home

68. When Sam arrived at the Trust at around 10.30pm, the paediatric consultant was on call at home. The paediatric registrar contacted the paediatric consultant to discuss Sam's condition, and he arrived at the hospital within ten minutes of that conversation. Having reviewed Sam and discussed how best to manage his condition, the paediatric consultant left the hospital.
69. Our Consultant Paediatric Adviser has commented that there was no evidence that the paediatric consultant had told staff to call him if Sam's condition deteriorated and thus 'safety netting' does not appear to have happened in Sam's case. However, we can also see that the paediatric registrar contacted the paediatric consultant twice during the period that Sam was deteriorating. The actions of staff at the Trust, therefore, indicate that they were aware that they could, and should, contact the paediatric consultant at home, if necessary.
70. We asked our Consultant Paediatric Adviser whether such instructions should be recorded in the notes or whether verbal instructions to staff in such situations were adequate. He told us that most instructions are verbal and it would not be common practice to write them down in the medical notes.
71. The paediatric consultant has explained previously that he thought that Sam was stable. He had reviewed Sam and discussed his care with a number of other clinicians. On balance, we do not think it was inappropriate that the paediatric consultant left the hospital when he did.

A plan was in place to manage Sam's condition, and staff were aware they could contact him at home if his condition deteriorated.

Summary

72. We have found that on arrival in A&E, Sam's condition was initially assessed adequately and appropriate antibiotic treatment was prescribed. However, we have also found that the necessary treatment, in the form of the antibiotics, was not given until much later. This was a critical service failure. We have also found that Sam did not receive the aggressive fluid therapy he required, he was not monitored and reviewed as often as he should have been, and doctors failed to transfer him to the intensive treatment unit or seek timely advice from a paediatric intensive care unit regarding his care. Overall, the care and treatment provided for Sam by the Trust fell well below the applicable standards and was service failure.

Bereavement support

73. We will now address Mr and Mrs Morrish's complaints that the Surgery and the Trust did not provide bereavement support for their family.
74. Established good practice in relation to bereavement support is set out in Good Medical Practice and the Bereavement Guidelines. The Trust should have also acted in accordance with its *Being Open* policy. The Surgery and the Trust should have responded flexibly to the Morrish family's need for bereavement support and should have, when appropriate, co-ordinated their responses.

The Surgery

75. Following Sam's death, the Surgery was in contact with Mrs Morrish's mother, and has told us it attempted to pass on messages of support to the family through her. The GPs told us that they thought that Mr and Mrs Morrish would not want to hear from them. While we acknowledge that doctors were trying to be sensitive and considerate of the fact that Mr and Mrs Morrish might not have wanted to hear from them, the principles underpinning bereavement support (as set out in the Bereavement Guidelines) stress the importance of communication and recognising loss.
76. It is clear that, at the Surgery, there were discussions about how best to support the family. What the Surgery did not do, however, was involve the family in those discussions. If the Surgery was mindful to work at a pace dictated by the Morrish family's feelings and needs (a point the Bereavement Guidelines advocate), it should still have made clear to the family what it was doing and why, and responded to what would have been best for them rather than assume what was best in the circumstances. The Surgery has recognised that in the absence of any direct contact, it should have made personal contact with the family (Annex A, paragraph 65). However, at the time, there was no clear communication and the doctors at the Surgery were not 'responsive in providing information and support' as Good Medical Practice requires.
77. Following Sam's death, the family needed to understand what had happened. The Surgery felt that the paediatric consultant was best placed to discuss the 'medical aspects of this tragedy'. Having taken account of the GP Adviser's comments, because the Surgery felt that Mr and Mrs Morrish needed more specialist help

to understand what happened, it was appropriate for it to consider that the paediatric consultant was best placed to provide answers about Sam's infection. Nevertheless, the Surgery should have liaised with the Trust and the paediatric consultant in order to agree who was going to provide the information the family needed, and when. It should also have explained to the family what it was doing. It did not.

78. In response to requests from Mr Morrish, the allocated GP visited him and Mrs Morrish on 17 January, and she discussed with them some support services that might be available. After the meeting, she said, she had found it difficult to make direct contact with the family and sent information to them by email. While we realise that the allocated GP was trying to help the family, we do not consider that emailing information about the bereavement support that might be available following the unexpected death of a young child was a sensitive means of communicating. The allocated GP has acknowledged that it was 'undoubtedly unsatisfactory'.
79. From the evidence we have seen, the Surgery provided information about bereavement support in a piecemeal way and there was confusion between the Surgery and the Trust about who was taking the lead in providing bereavement support. While the Surgery made various offers of support, they were drip fed to the family, often in response to requests from the family and as a consequence of Mr Morrish's own persistence in seeking support. Even when the Surgery agreed to refer the family to a private counsellor, it did not pass the family's details to the counsellor and another month without support went by. The Surgery has told

us of the difficulties it experienced in sourcing bereavement support, especially for Sam's brother,⁷ and noted that information about bereavement support should be readily available. The Surgery has also recognised there were '*unacceptable delays*'. The allocated GP has told us '*it was difficult to keep a sense of momentum and know exactly what was required but this did not reflect a lack of interest or concern*'.

80. Overall, we have found that the service provided by the Surgery in respect of bereavement support fell far short of the principles set out in the Bereavement Guidelines. This was service failure.
81. Even after the privately-funded counselling began, the family had to involve themselves in discussions about securing ongoing support, which would not have been necessary had there been a considered, co-ordinated and responsive approach to bereavement support. We acknowledge that the PCT has told us that ongoing funding was never in question, and after discussions between Mr Morrish and the Surgery about counselling, the PCT agreed to pay for four further sessions. However, no one at the Surgery spoke to either Mr or Mrs Morrish about how much more counselling the family might need and Mr and Mrs Morrish should not have had to become involved in discussions about funding. The Surgery again failed to act in accordance with the Bereavement Guidelines as it did not work at the pace dictated by Mr and Mrs Morrish's needs.
82. Having said that, Mr and Mrs Morrish have told us that they feel it is important to acknowledge the efforts the Surgery did

make, which were supportive to them in the context of their bereavement. For example, they have said that the Surgery ensured that at around the time of the first anniversary of Sam's death, they knew how to access their services to avoid having to go into the Surgery that week. Mr and Mrs Morrish have said that this arrangement was considerate towards them and unprompted. They have also said that the Surgery has shown genuine remorse for what happened to Sam and that although, in respect of organised bereavement support it failed, in all other respects its contact with the family was sympathetic and considerate.

The Trust

83. In line with the Trust's own policy (*Being Open*), the paediatric consultant was in contact with the family immediately after Sam died, discussed the preliminary post mortem results when they were available and arranged a meeting after a couple of weeks to discuss what had happened. The Trust was also quick to give the family contact details for its bereavement office. However, *Being Open* also says that information about counselling or support services should be given.
84. The paediatric consultant met the family on 17 January and reportedly told Mr and Mrs Morrish that his team was available to provide support and he could explain to their friends and family what had happened. He also explained that the family might experience flashbacks but they could call him as often as they liked. His comments bore in mind the family's circumstances. It is clear that, at this time, the family were struggling to cope, and had

particular concerns about Sam's brother. The paediatric consultant explained that support groups were available, including Winston's Wish, which might have been able to help Sam's brother.

85. While he highlighted Winston's Wish, there is no evidence that any information about how to contact the organisation, or how it might have benefitted Sam's brother, was given to Mr and Mrs Morrish. Furthermore, the paediatric consultant said that there might be another organisation that could help Sam's brother, but he could not remember who it was. This shows that he had not fully prepared for the meeting. At the very least, he should have agreed to find out this information, and give it to the family, but he did not. While the paediatric consultant offered support to Mr and Mrs Morrish at the hospital, there was no co-ordinated effort from then on to make sure the family had appropriate ongoing support. The evidence also suggests that the paediatric consultant was unaware of what support was available. It was only after the child death review meeting in May that he realised that the public health nursing team could have helped.
86. The paediatric consultant told us he thought the main responsibility for providing bereavement support fell to the Surgery. In turn, the allocated GP told us that '*this was a rather specialist area of bereavement care and the hospital was likely to have more specific expertise especially with regard to support for [Sam's brother]*'. While the Trust and the Surgery clearly contacted one another about the support the family needed, there was no co-ordinated response between the two organisations. This is illustrated in the way access to psychological support was arranged. Neither organisation had a

thorough knowledge of the services that were available or was fully aware of what, if any, support was being provided by each organisation. This was wholly inadequate.

87. In summary, the Morrish family's access to bereavement support was hampered by poor communication and the lack of a co-ordinated effort. Neither the Surgery nor the Trust demonstrated the principles set out in the Bereavement Guidelines. The Surgery's and the Trust's actions in relation to providing or facilitating suitable bereavement support fell far short of the applicable standards and were service failure.

Injustice

88. Having found service failure in the care and treatment provided for Sam by the Surgery, NHS Direct, Devon Doctors Ltd and the Trust, we now consider the impact that service failure had on Sam and his family.
89. To summarise, we have found service failure in each area of the care and treatment provided to Sam by each organisation he came into contact with before he died. We have also found that, although as time went on Sam's chances of survival were likely to be diminishing, at each stage of the care provided, had Sam received the appropriate treatment, it is likely he would have survived.
90. Our Consultant Paediatric Adviser has warned that some children with sepsis can still develop complications and die, even if they receive appropriate treatment. However, he has also said that if Sam had been referred to a paediatric specialist by the Second GP at 4.30pm on 22 December, on the balance of probabilities, a significant infection would have been identified and Sam would have been given

⁷ We recognise that the allocated GP provided some information to the family about support for Sam's brother when she visited them on 17 January 2011. However, this was insufficient and Mr and Mrs Morrish had to contact the PCT to obtain further support.

broad-spectrum antibiotics. On that basis, we consider that if Sam had received antibiotics earlier on 22 December, he would almost certainly have survived.

91. We also consider that if Sam had been referred to hospital by the NHS Direct nurse adviser, or he had been assessed sooner by Devon Doctors Ltd and referred to hospital at that point, it is highly likely that he would have survived.
92. In fact, even though Sam was very ill by the time he got to hospital late in the evening of 22 December, a further opportunity to provide timely treatment was then lost because of the unacceptable delay in giving him the antibiotics he was prescribed. Our Consultant Paediatric Adviser commented that, had the failures identified in the care and treatment at the hospital not occurred, it is likely Sam would have survived. However, by the time he actually received antibiotics his chances of surviving had significantly diminished and, even with maximal intensive care, were low.
93. It is also clear that the repeated failures by the NHS when treating Sam undoubtedly caused Mr and Mrs Morrish a great deal of anxiety and distress as they watched Sam's condition deteriorate and did what they could to draw attention to it.
94. As a consequence of the failures we have identified in providing Mr and Mrs Morrish and their family with appropriate bereavement support, they were effectively cast adrift in their grief, left unsupported and had to seek the help for themselves and Sam's brother that should have been offered to them. This was unacceptable and no doubt compounded the significant distress they experienced. Mr and Mrs Morrish say they were left having to deal with the distressing death of their son without help and their

description of that period as a '*bleak*' and '*very lonely*' time seems very measured. They were badly let down and the lack of bereavement support during this traumatic period in their lives meant they suffered additional and wholly unnecessary anxiety and distress.

95. It is clear that the NHS failed Sam and his family. As a consequence, Sam died when, on the balance of probabilities, had it not been for the faults identified, he would have lived. The devastating impact of Sam's untimely death, and the knowledge that it could have been avoided, is an injustice they will continue to suffer.

How Mr and Mrs Morrish's complaint was handled

96. Mr and Mrs Morrish highlighted numerous concerns about Sam's care to the Surgery, NHS Direct, Devon Doctors Ltd, the Trust and the PCT. They wanted to know what had happened to their son and how he came to die. They also wanted the organisations to learn from their mistakes and they wanted their confidence in the NHS to be restored. Each organisation involved in Sam's care had a responsibility to investigate fully and to respond to the family's concerns.

The Surgery

97. The Surgery began its own review, which included obtaining statements from the First GP and Second GP about their assessments of Sam. In doing so, the Surgery took steps to establish the facts of the case. We also note that the Surgery contacted the PCT for advice on how to proceed with an investigation and the PCT told the Surgery on 18 January that a root cause analysis was to be conducted. However, the Surgery had an opportunity to directly address the concerns that Mr and Mrs Morrish had raised in respect of Sam's care and treatment at the meeting that took place on 25 January.
98. The meeting was arranged promptly and was an appropriate way to give the family the explanations they sought. However, although the Surgery said that it valued feedback, the minutes suggest that the meeting largely consisted of the GPs saying that Sam had not seemed seriously ill when they assessed him. The GPs acknowledged that Sam had been developing a serious infection, but they said his symptoms did not suggest this when they saw him. The Surgery did not refer to any objective justification about why the GPs' actions were appropriate in the circumstances or what clinical standards influenced their actions.
99. Furthermore, although the Surgery highlighted a number of learning points that it had identified following Sam's death, it did not directly address Mr and Mrs Morrish's specific questions. For example, when they asked if earlier antibiotics would have helped Sam, the Surgery said that the symptoms did not indicate he had a bacterial infection, thereby not answering the specific point raised. Having said that, the Surgery apologised to Mr and Mrs Morrish during the meeting for the failings it had investigated. It also accepted and acknowledged what it referred to as '*clumsiness*' in dealing with the period immediately after Sam's death and apologised for the failure to contact the family promptly and provide appropriate bereavement support.
100. At the same time that the Surgery met Mr and Mrs Morrish, it was aware that the PCT was going to conduct a root cause analysis of the circumstances surrounding Sam's death. The Surgery told the family that the PCT would be conducting an investigation but did not explain the steps it had agreed to take after its internal meeting on 7 January 2011, nor what a root cause analysis involved, its role in that process, and who the family could contact about the ongoing investigations into Sam's care. Nor did the Surgery send the family's comments and concerns to the PCT at that time. This was not helpful.
101. As part of their complaint to us, Mr and Mrs Morrish have expressed concern that the Surgery was unwilling to attend the root cause analysis meeting on 4 April

without the PCT's agreement to fund a locum GP. We have not seen any evidence that the discussions that took place demonstrated an unwillingness to attend the meeting on the part of the Surgery. Rather, we consider that those discussions demonstrate that the Surgery recognised it had a responsibility to ensure it provided ongoing GP services to its patients.

102. Mr Morrish emailed the Surgery on 14 July with a list of questions. There is no evidence that the Surgery responded directly to Mr Morrish. Although he had copied his email to the independent investigators, it would have been reasonable to expect the Surgery to acknowledge this email and inform Mr Morrish that it was relying, appropriately in our view, on the independent investigators to ensure that his concerns were dealt with as part of their investigation.

103. In summary, the Surgery took a number of positive actions when attempting to respond to Mr and Mrs Morrish's concerns. It began its own review, took steps to establish the facts of the case and contacted the PCT for advice on how to proceed with an investigation. However, the explanations it gave the family both in relation to the care provided and the lack of bereavement support, were poor. Although the Surgery highlighted a number of learning points that it had identified following Sam's death, it did not address Mr and Mrs Morrish's specific questions. It did not give the family the information it had available about the PCT's investigation, nor did it pass the family's concerns to the PCT. Overall, the actions of the Surgery when responding to the concerns raised by Mr and Mrs Morrish amounted to maladministration.

NHS Direct

104. NHS Direct was not aware of Sam's death until March 2011. When it was told about his death, it sent a letter of condolence to the family. NHS Direct told Mr Morrish it was conducting a review; that the findings would be shared with the family; and that he could contact the chief executive if he needed more information. However, before it began its review, NHS Direct had not spoken to Mr and Mrs Morrish, or attended the root cause analysis meeting. Given this, we cannot see that NHS Direct could have hoped to have had a clear understanding of their concerns or the outcomes they sought.

105. In May, in response to a request from Mr Morrish for information, NHS Direct sent him copies of various policies and the recordings it held of Mrs Morrish's call to its service. However, there is no evidence to demonstrate that NHS Direct considered whether it was appropriate to simply send the voice recordings to Mr Morrish to listen to alone. We think it should have thought about what other information or explanations it could have shared with him at this point, given that it was aware that the recordings revealed that the NHS Direct nurse adviser should have made an urgent, rather than a routine, referral when dealing with Mrs Morrish's call.

106. NHS Direct's investigation of Mrs Morrish's call to its service involved independent clinicians and highlighted a number of failings. The results of the investigation were shared with the family in June 2011. These included the fact that the NHS Direct nurse adviser recorded the wrong answers to questions and noted that, had the NHS Direct nurse adviser acted appropriately, '*a higher level of care may have been recorded*'. The chief

executive apologised that the NHS Direct nurse adviser's assessment '*was not of the high standard we expect*'. However, in subsequent correspondence with Mr Morrish, the chief executive went even further and acknowledged that had the NHS Direct nurse adviser not made the errors she did, the algorithm '*would*' have recommended Mr and Mrs Morrish take Sam to A&E. It is not clear on what basis the chief executive went further in his follow-up correspondence with Mr Morrish. However, it is clear that he failed to identify the severity of the error made by the NHS Direct nurse adviser. It is also clear, and has been acknowledged by NHS Direct, that the review took longer than it should have. NHS Direct has acknowledged that while it should have completed its investigation within 28 days, it took almost two months for this to be concluded.

107. Turning to the actions of NHS Direct in relation to the PCT's investigation, NHS Direct received notice of the initial root cause analysis meeting on 30 March 2011. NHS Direct told the PCT it was too short notice to send a representative to the meeting due to take place on 4 April. Although we recognise that it may not have been possible for the person who received the emails to attend, there is no evidence that NHS Direct took any steps to see if someone else could attend instead. This was a failure and we note that the chief executive has acknowledged that someone from NHS Direct should have attended the meeting. It would also have been reasonable to expect it to send the PCT a copy of the relevant recordings proactively. It did not. Furthermore, when asked for a copy of the recordings, NHS Direct failed to provide them in a timely manner. As it was, Mr Morrish sent the PCT a copy of the recordings, not NHS Direct. This is unacceptable.

108. Overall, NHS Direct did not deal with the concerns raised by Mr and Mrs Morrish appropriately. It did not always act promptly; was inflexible in its collaboration with the PCT, and failed to give an evidence-based response, or reasons for the NHS Direct nurse adviser's decisions. The actions of NHS Direct fell so far below the applicable standards that they amount to maladministration.

Devon Doctors Ltd

109. Devon Doctors Ltd were informed of Sam's death by the PCT in March 2011. They did not proactively contact Mr and Mrs Morrish to discuss any concerns they might have had. We understand that they were of the view that the PCT was leading the investigation. However, it would have been appropriate for Devon Doctors Ltd to write to Mr and Mrs Morrish, if only to acknowledge the death of their son and tell them that they would be participating in the root cause analysis investigation. They did not. In fact, they did not make direct contact with Mr and Mrs Morrish for another two months, and then only after the PCT had asked them to.

110. Over the course of the investigations into Sam's death, Devon Doctors Ltd corresponded directly with Mr and Mrs Morrish in response to continued concerns raised by the family about the care provided to their son. In their initial correspondence, Devon Doctors Ltd said that, having reviewed the care provided for Sam, they were '*unsure in the circumstances we could have responded any differently*'. It is not clear how evidence-based this review was, however, given their conclusions, it is clear that it was not robust enough.

111. Following the meeting on 25 May (Annex A, paragraph 101), Mr Morrish raised further

concerns, including a complaint that at this meeting, Devon Doctors Ltd made reference to the fact that alcohol could cause blood in vomit. They told us that they could not remember making such a statement but, had they done so, it would have been in the context of explaining how blood in adults' vomit can be caused by alcohol. Given Devon Doctors Ltd's explanation, it seems likely that it was in context. Such an explanation in these circumstances would have been irrelevant, insensitive and unacceptable. Mr and Mrs Morrish were also very unhappy because they felt that Devon Doctors Ltd had spent the first 30 minutes of the meeting telling them how busy they were that night. This appears to be confirmed by the fact that in a letter to Mr and Mrs Morrish, Devon Doctors Ltd said that they could 'not excuse' failings but that failings had to be seen in the context of that night's workload. Such statements under these circumstances are not appropriate or justifiable in the circumstances, nor do they indicate a willingness to learn from incidents such as this.

112. In their correspondence, Devon Doctors Ltd acknowledged a number of failures in the service provided, and apologised. They did not, however, answer Mr Morrish's concerns about why they had done what they did. Furthermore, it is apparent, given Devon Doctors Ltd's first response, that it was Mr Morrish's strong challenge, after he had listened to the recordings, that drew their attention to the failures that they went on to acknowledge. It is also apparent that Devon Doctors Ltd failed to recognise fully their role in what had happened to Sam and in the investigation by the PCT. Following receipt of the PCT's root cause analysis report, Devon Doctors Ltd told Mr Morrish that *'it remains the view of Devon Doctors Ltd that the errors made*

that evening did not [in their view] delay Sam's care'. They also said that while they *'had a role within the [root cause analysis] we did not think our role was central'*.

Such comments were not only insensitive but inaccurate, given our finding that, had Devon Doctors Ltd provided appropriate care and treatment, Sam would probably have lived. There is no evidence that Devon Doctors Ltd considered the impact of the failings that had been identified. For example, how much sooner an ambulance could have been called had the failings in call handling not happened.

113. Devon Doctors Ltd was not immediately made aware that Sam had died or that Mr and Mrs Morrish had questions about the care he had received. We recognise that the way the PCT communicated with Devon Doctors Ltd gave the impression that it was leading an investigation into their concerns. However, Devon Doctors Ltd did not proactively engage with Mr and Mrs Morrish outside the root cause analysis process. When they did engage with the family, they did not give evidence-based statements, made inappropriate and irrelevant comments and failed to understand the heart of Mr and Mrs Morrish's complaints and the outcomes they sought. Furthermore, although Devon Doctors Ltd responded appropriately to initial requests for information from the PCT during its investigation, they should have gone further and been more proactive, for example, by sending the PCT available transcripts of the telephone conversations between Mrs Morrish and Devon Doctors Ltd. The actions of Devon Doctors Ltd when dealing with Mr and Mrs Morrish's complaints amounted to maladministration.

The Trust

114. Following Sam's death, the Trust began a significant event review and held an internal review meeting. On 10 January 2011 the Trust was made aware by the PCT that Mr and Mrs Morrish were keen to meet to discuss what had happened to Sam.
115. The paediatric consultant met the family on 17 January to discuss their concerns and the preliminary post mortem results. It is clear that the paediatric consultant failed to properly address some of the questions put to him at the meeting. Nor is it clear on what basis he gave certain responses. For example, when asked about how long the delay was in giving Sam antibiotics, the paediatric consultant accepted that he probably told Mr and Mrs Morrish that it was around 90 minutes, as opposed to between two and a half to three hours, as shown in the medical records, and which was the actual delay. Also, when asked about the impact of the delay in providing antibiotics on Sam's condition, the paediatric consultant said that in another case, earlier antibiotics had not prevented a child's 'collapse', however, he did not answer the question in respect of Sam's condition. Furthermore, given that some of the answers to the questions asked were in the medical records, it would appear that the paediatric consultant had not properly prepared for the meeting by reviewing Sam's records. A further failure was that the paediatric consultant did not give Mr and Mrs Morrish any details of the scope and purpose of the review that the Trust was conducting.
116. The Trust continued with its own review, alongside the PCT's root cause analysis and obtained statements from some of the staff involved in Sam's care. The statement from the paediatric registrar was not

obtained until late June 2011. Furthermore, a statement from the paediatric consultant was not taken as part of this review because the Trust felt it had enough information (from Sam's medical records and the notes of the meeting between the paediatric consultant and Mr and Mrs Morrish). This was a failure.

117. We have already said that we cannot say for certain why there was such a significant delay in Sam being prescribed antibiotics and the antibiotics being given. This is a crucial area of Mr and Mrs Morrish's concern and one that they deserved a clear answer to, if it was at all possible to provide one. The chance to answer this question would have been as soon after the incident as possible. As it was, statements were taken from some staff, but not until eight weeks later. Furthermore, the question of why the delay occurred has been mired in confusion, and further explanations have been given as recently as January 2014 – over three years after Sam's death. This is unacceptable, and is clear maladministration. A further concern is the time it took the Trust to recognise the significant impact of this delay: that had Sam been given the antibiotics soon after they were prescribed, it is likely he would have lived.
118. Mr and Mrs Morrish are unhappy that the paediatric consultant did not attend the (second) root cause analysis meeting on 28 June. They said to us that they were told that was a non-working day for the paediatric consultant. However, the paediatric consultant told us that he did not attend because he felt it would be inappropriate when his own clinical competence might be discussed and he did not want to compromise the independence of the meeting.

119. The purpose of the meeting was to discuss the root cause analysis investigation, and then to agree the terms of reference for a new and independent review of Sam's care and the subsequent handling of Mr and Mrs Morrish's concerns. On that basis, regardless of the reason for his absence, he should have attended the meeting. Instead, the Trust sent a different paediatric consultant to the meeting. This was not acceptable.

120. It is clear that the Trust failed to thoroughly investigate Mr and Mrs Morrish's complaints and key aspects of Sam's death, or give reasons for the decisions made about Sam's care. The Trust's actions when dealing with Mr and Mrs Morrish's complaint amounted to maladministration.

The PCT

The root cause analysis investigation

121. On 18 January 2011, following the decision to conduct a root cause analysis, the PCT contacted the Surgery and the Trust to arrange a meeting. However, it took them until 9 March to arrange the meeting. Furthermore, the PCT made no attempt to contact Mr and Mrs Morrish, who were only aware of the investigation because the Surgery had told them about it.

122. By the time the meeting took place, on 4 April, the PCT had not sought any clarification from Mr and Mrs Morrish regarding their concerns or outcomes they were seeking. In fact, the PCT did not tell them about the purpose of the meeting until after it had taken place.

123. Despite the references by the PCT to a 'joined-up' investigation, the PCT largely left the organisations involved to carry on with their own investigations with no

guidance about what was required (aside from chronologies). This was clearly not a 'joined-up' approach. Furthermore, it was not until March that the PCT contacted Devon Doctors Ltd and NHS Direct, because until this point they had not known that these two organisations had assessed Sam. Had they spoken to Mr and Mrs Morrish at the start of the process, they would have been able to tell the PCT who else had been involved in the care provided to Sam.

124. Once the PCT realised that NHS Direct and Devon Doctors Ltd were involved, it made the necessary arrangements to include them in the meeting. However, despite what we have said in relation to our findings about NHS Direct and its failure to attend this meeting, the PCT must accept some responsibility for this. The PCT was clearly aware that the person it was emailing was out of the office until just before the meeting was due to take place. We consider that common sense should have suggested that the PCT should try to contact someone else in the organisation. However, it did not do this.

125. The PCT continued to demonstrate that the investigation was in fact not 'joined-up'. It did not liaise with or take account of NHS Direct's investigation and the terms of reference noted that it (the PCT) would only consider events up to Sam going to hospital, at which point the intention was to add the results of the Trust's investigation. Furthermore, although the PCT attempted to obtain evidence from NHS Direct and Devon Doctors Ltd in the form of the voice recordings, it did not proactively chase them when they did not arrive and, as referenced above, it was Mr Morrish who sent the PCT the information it needed in the end. This was unacceptable.

126. The PCT sent a report to Mr and Mrs Morrish on 14 June, however, it was incomplete. It contained very little information about NHS Direct's involvement, at this point it had not completed its investigation, nor did the report accurately reflect the comments made by the Trust about why Sam had not been given antibiotics earlier. The final report was issued on 24 June (a copy of this report is at Annex E).

127. Given the process followed by the PCT, it is unsurprising that the report failed to give Mr and Mrs Morrish evidence-based responses, including why it considered there had been '*no unexplained moments that would have constituted a delay* [in Sam's treatment]'. Mr Morrish has accurately described it as a disjointed '*paper-based exercise*'. It is clear that the PCT simply collated information it had about the individual organisations' own investigations. There was very little independent, critical analysis by the PCT and no independent clinical review of the care Sam received. As such, any learning noted in the report simply reflected what individual organisations had themselves identified. The PCT failed to listen to Mr and Mrs Morrish's concerns, deal with the family promptly, co-ordinate responses with the other organisations or act flexibly in how it dealt with those organisations. As a result, the root cause analysis failed to understand why the NHS had failed Sam. The investigation was woefully inadequate and the actions of the PCT were clear maladministration.

The PCT's second investigation

128. It was agreed that a second investigation would take place and, during the meeting on 28 June, the Chair of that investigation, who at Mr Morrish's insistence was

independent of the PCT (Annex A, paragraphs 116 to 119), set out the terms of reference. These included listening to Mr and Mrs Morrish's opinions, applying clinical judgment to what had happened, and identifying learning. Crucially, no one involved in the events complained about would be involved in producing the report, and two independent investigators would conduct the investigation. A timescale was set for completing the review. This suggests that the investigation was set up appropriately.

129. However, Mr Morrish was concerned that the investigators involved only met the GPs from the Surgery at their request and because he had insisted that the investigation should not be a paper-based exercise. He also believes that the paediatric consultant should have been interviewed in person, and was spoken to by one of the investigators only out of professional courtesy. The evidence shows that the independent investigator discussed Sam's care with the paediatric consultant to try to establish why there was a delay giving Sam antibiotics and there is no indication that the paediatric consultant was interviewed only out of courtesy. We consider that in these circumstances, telephone interviews are a reasonable way of establishing facts. Furthermore, while it is clear from the evidence that we have seen that Mr Morrish was keen that the clinicians involved were interviewed as part of this piece of work, we have also seen evidence that the independent investigators had always considered that it might be necessary to interview clinicians.

130. As part of their investigation, the independent investigators spoke to Mr and Mrs Morrish about their experience of getting bereavement support, and

- reviewed statements obtained during the root cause analysis investigation. However, Mr and Mrs Morrish were unhappy that the independent investigators did not speak to them about the clinical aspects of Sam's care before the meeting on 30 August. We agree that it could have been beneficial for the investigators to discuss all aspects of the complaint with Mr and Mrs Morrish including the clinical care to ensure that they had fully understood what had happened during Sam's interactions with the various organisations. The fact that the independent investigators did not was a failure.
131. The investigators spoke to staff responsible for bereavement support in the region and took account of information the Trust sent them in August, and the various contacts Mr and Mrs Morrish had had with the Surgery and the Trust after Sam's death. Having reviewed the evidence, we are satisfied that, with the exception of ensuring they understood Mr and Mrs Morrish's perspective on the clinical care Sam received, the investigators adequately established the facts when they concluded there was a lack of clarity between the Trust and the Surgery about responsibility for managing bereavement support.
132. Accepting that the clinical care provided was the most crucial aspect of the investigation, the information the investigators gathered for the purposes of their investigation was incomplete. Furthermore, although both investigators had medical backgrounds (nursing and paediatrics), and were in a good position to review the paediatric and nursing care Sam received, neither of them was in a position to peer review GP, or out-of-hours GP, care. The terms of reference for the investigation included applying clinical judgment to what had happened. That could only have been done thoroughly and effectively if someone with knowledge of delivering GP and out-of-hours care reviewed what happened. The investigators sought no input or advice from an independent GP. Therefore, Mr and Mrs Morrish's concerns about the Surgery and Devon Doctors Ltd were not thoroughly or robustly investigated.
133. The independent investigators' report into the PCT's root cause analysis process largely identified what had gone wrong with the process, including that the PCT had failed to quickly identify all the organisations involved in Sam's care, involve Mr and Mrs Morrish, or obtain expert clinical opinion about what had happened. They also identified that there had been confusion about who was leading the investigation. The independent investigation report included a three-page statement from the chief executive of the PCT (Annex F) in which she admits '*the quality of the investigation into the events surrounding [Sam's] death – and the subsequent report – was completely unacceptable*'. She unreservedly apologised and explained that the PCT would improve its investigations in the future. When considered in the round, the independent investigation report made evidence-based decisions about the root cause analysis process.
134. However, the report failed to address all of Mr and Mrs Morrish's concerns. For example, the report failed to give a definitive answer about when Mr and Mrs Morrish should have been told to take Sam to hospital, and whether earlier treatment would have resulted in Sam surviving. There is no analysis of whether Sam would have survived had the family been told to take him to hospital earlier on 22 December (following assessments by the Surgery, NHS Direct or Devon Doctors Ltd). Mr and Mrs Morrish's questions about service provision at Devon Doctors Ltd were overlooked. And while the report acknowledged that there was a delay in giving Sam antibiotics, it did not conclude whether this was a failure. Although the independent investigators were aware of Mr Morrish's ongoing concerns about the Surgery, including the adequacy of the telephone assessment on the morning of 22 December 2010, the second investigation did not answer this issue.
135. The Chair of the second investigation told us that it did not set out to '*get to the bottom of everything*', but to get the organisations involved in Sam's care to acknowledge what went wrong and to put it right. However, the investigation had to consider all aspects of Sam's care before those organisations could acknowledge all the failures and know what needed to change in future. The terms of reference clearly set out that the investigation should apply clinical judgment to what happened, and identify root causes and contributory factors (including the telephone assessment by the Surgery, and Devon Doctors Ltd's service provision). By definition, a root cause analysis should have included reviewing '*everything*' to establish what happened, that is, to get to the root of the problems. However, the Chair felt that it was necessary to '*draw a line*' under the second investigation process, and by acting in this way, the investigation process did not meet the terms of reference agreed at the meeting of 28 June. The second investigation, although an improvement, was not thorough and did not give Mr and Mrs Morrish evidence-based answers about Sam's care.
136. Mr and Mrs Morrish met the investigators and were given the second investigation report on 30 August, before the report was to be 'signed off' by the Chair the following day. This meant that the first chance Mr and Mrs Morrish had to review it was at the meeting on 30 August. Mr and Mrs Morrish had to read the report, and were expected to comment on it, during the course of an eight-hour meeting. The independent investigators were aware of how much detail was in the report, and although they were working to a deadline and eager to meet it, the way in which the family were presented with, and expected to comment on, the report was wholly unreasonable and was no doubt very distressing for Mr and Mrs Morrish.
137. Mr Morrish had, at the outset, asked the independent investigators to arrange a meeting for after the report had been completed in case he had any further unanswered questions. Once the final report was signed off on 31 August, Mr and Mrs Morrish clearly had unresolved queries. Yet despite Mr Morrish emailing the independent investigators, and the Chair, about his concerns, he did not get answers to his outstanding questions. Mr Morrish asked for copies of documents referenced in the report but he was not sent them. It was apparent that the independent investigation had come to an end, and the PCT then took an inflexible approach to dealing with Mr and Mrs Morrish's ongoing concerns.
138. The PCT's independent investigation left a number of questions unanswered. The terms of reference of the second investigation stated that the investigation would '*span the "whole system" taking into account the issues and findings within individual organisations*'. The PCT's second investigation again failed to thoroughly

investigate Mr and Mrs Morrish's concerns. While we recognise that the Chair felt it was necessary to 'draw a line' under the investigation, we agree with Mr Morrish's view that the second investigation 'fizzled out'.

139. The chief executives of NHS Direct, Devon Doctors Ltd, the Trust, and the PCT, as well as the Chair, met on 30 September to discuss the independent investigation report. Such a meeting could have been helpful to ensure that the organisations had reviewed and accepted the investigation findings. However, the Surgery was not invited. In fact, it only found out about the meeting through Mr Morrish. The Surgery should have been invited, so at this late stage, the PCT still failed to co-ordinate a response from all of the organisations involved.
140. Overall, the second investigation failed to deal with Mr and Mrs Morrish sensitively, listen to their complaints and respond flexibly to their needs. Key issues were not thoroughly investigated and the PCT did not give the family the evidence-based answers they were entitled to. Furthermore, the process by which an apparent 'draft' report was shared with the family was wholly unreasonable. This was maladministration.
141. It should be noted that following Mr and Mrs Morrish's concerns about the second investigation, the PCT agreed to a further review. However, by this time, Mr and Mrs Morrish had understandably lost faith in the NHS and its ability to investigate its own mistakes.

Injustice

142. As a consequence of the many failings in complaint handling – by all five organisations involved – Mr and Mrs Morrish were left without a comprehensive understanding of what had happened to Sam. The disjointed nature of the investigations meant that the family received information piecemeal, and reports included contradictory and incomplete information. Because he did not get adequate answers to his questions, Mr Morrish was left with no evidence, or confidence that the organisations involved could identify or understand the failings that occurred, learn, improve and 'put things right'.
143. Because of the lack of a co-ordinated effort, Mr Morrish had to constantly battle to try to get his questions answered. That should not have been necessary at such a difficult time for the family. It can only have increased their distress. The evidence shows a demonstrable failure to put the family at the heart of the investigations or fully investigate their concerns. We can well understand how Mr and Mrs Morrish have lost faith in the NHS and say that it is '*incapable of openly, honestly and accurately investigating its own failings*'.

Key findings and recommendations for improvement

The Surgery

144. We found in paragraph 29 of this report that the absence of guidance for the reception staff at the Surgery to help them assess the priority level of each call received was a service failure. We are pleased to note that since these events, the Surgery has installed a new telephone triage system, which has involved reception staff being trained in how to direct patients through the system. However, we think that when Mrs Morrish spoke to the receptionist, she had a right to know what level of service she could expect. We recommend that the CCGs work with the Surgery to produce guidance for patients as well as staff and that this information should be published.
145. When they saw the Second GP Mr and Mrs Morrish say Sam's temperature was lower than it was the day before but that his condition had worsened. They told us that the Second GP took Sam's temperature but he did not record it. As there are no records available we cannot know for sure what Sam's temperature was at this appointment, though it seems clear from Mr and Mrs Morrish's recollection that Sam's temperature fluctuated over the two day period. Mr and Mrs Morrish have asked us to note in this report that when a child's temperature lowers in this way yet their condition worsens it can be considered a sign of sepsis. We agree that this seems likely to have been the case here. Unfortunately due to the poor record keeping we cannot make a finding on this point.

146. We have also noted in paragraph 34 that the Second GP has accepted he did not document Sam's heart rate and has said that the traffic light system does not include the need to record the heart rate. However, this case has highlighted that, while it is correct that the traffic light system does not include a reference or requirement to measure the heart rate, Feverish Illness in Children specifically states that the heart rate should be measured and recorded.
147. We recognise that the guidance is lengthy and the traffic light system is intended to be a quick reference guide. However, we think that this case demonstrates the importance of measuring and recording a child's heart rate in these circumstances. As such, we think NICE should consider making the requirement to measure and note the heart rate a specific element of the traffic light system. We will be sending a copy of this report to NICE so that they can consider taking this forward.

NHS Direct

148. One of the most crucial aspects of the care and treatment Sam received was the conversation that Mrs Morrish had with NHS Direct. In this case, the NHS Direct nurse adviser failed to accurately record the answer Mrs Morrish gave to what seems to have been the most important question asked - whether or not there was blood in Sam's vomit. Had the NHS Direct nurse adviser answered this question correctly, Mrs Morrish would have been told to take Sam to A&E.
149. We must take into account the fact that the NHS Direct nurse adviser did not answer other questions correctly and that at the end of the call, she had a duty to consider whether what she had heard should prompt any action other than that

recommended by the algorithm. We also note that the algorithm NHS Direct used at the time of these events has since been changed. However, the events of this case strongly suggest that the question of whether or not Mrs Morrish's call was treated as urgent relied heavily on the answer to one question. Given that these situations still occur under the NHS 111 service, and the importance of accurate telephone triage, we think that NHS England and NHS 111 should review the sets of questions that call handlers ask. This should be with the aim of assuring themselves that adequate safety nets are in place to allow for emergency situations to be safely dealt with on the occasion that something goes wrong.

Devon Doctors Ltd

150. It is clear that on the night that Sam died, Devon Doctors Ltd were providing a service that was under pressure in winter in the midst of a flu epidemic. Devon Doctors Ltd have said that they could '*not excuse*' the failings but went on to say that the failings had to be seen in the context of that night's workload. As we have said in paragraph 111, we do not think that this indicates a willingness to learn from incidents such as this. That a service is busy does not justify poor care.
151. We recognise that Devon Doctors Ltd had in place a '*robust contingency plan*' in line with the guidelines at the time. However, the failures that occurred here clearly demonstrate that there were problems with the service they were providing. NHS organisations need to satisfy themselves that the contingency plans they have in place actually work by testing and evaluating them on a regular basis and subsequently reviewing them in light of that experience. We consider that the guidelines need to be reviewed in order

to ensure that it is a specific requirement that NHS organisations demonstrate that their contingency plans are regularly tested, reviewed and their strengths and weaknesses identified and addressed.

The Trust

152. It is clear that one of biggest opportunities that was lost to save Sam's life was the delay in administering the properly prescribed antibiotics. Had the antibiotics been administered in a timely manner Sam would have lived. Furthermore, the lack of an urgent and robust investigation into this failure has led to a situation where we think it is simply not possible to establish how this occurred. This is a significant failing.

Mr and Mrs Morrish's contact with the 'whole NHS'

153. During the period of care that we have investigated, Sam and his parents came into contact with four different NHS organisations, some of them repeatedly. This was over a period of less than 48 hours. We have noted that each time they got in touch with the NHS, or were assessed, very little account was taken of the previous contact they had had with the NHS.
154. Each time the Morrish family contacted a different part of the NHS, they were more worried about their son's condition. This should have been apparent to the organisations they contacted and prompted a more urgent response. Instead, from what we have seen, if an organisation took a previous contact into account, if anything it was reassured by the previous contact rather than concerned about it.
155. This is a significant lesson for the whole NHS. We believe that the repeated contact the family had with their local NHS services, and the services' apparent failure

to respond to that repeated contact, is in itself a service failure. We think this failure has further compounded the injustice felt by the Moorish family following Sam's death. The family relied on their local NHS services to treat their son, as they had a right to do. It is clear from the family's actions that they were becoming increasingly anxious and concerned about Sam's condition. Yet the services they encountered did not always listen to those concerns. We think that high levels of contact from parents in short periods of time should be seen as a cause for concern and raise the alarm. We think NHS England should consider the importance of this and how the current guidance for all NHS providers can be amended in order to make sure that NHS organisations listen to parents in Mr Morrish and Mrs Morrish's position.

Bereavement support

156. The lack of bereavement support for the family was crucial. We note that when it considered helping the family understand what had happened, the Surgery felt that Mr and Mrs Morrish needed specialist help to do this. The Surgery thought it could not provide this but that the paediatric consultant could. However, we note that the paediatric consultant felt the main responsibility for bereavement support fell to the Surgery.
157. It seems to us that in this case, both the Surgery and the Trust (the paediatric consultant in this instance) had a role in providing bereavement support but neither was sufficiently clear about what that role was, nor were they sufficiently clear about what support was available to families in Mr and Mrs Morrish's position. This meant that the family were left without any access to bereavement support for some time after Sam's death.

158. It seems likely that local services, such as GP surgeries, are often the first port of call when families are in the terrible situation that Mr and Mrs Morrish found themselves in. We also recognise that in many cases others involved in the care of a child such as Sam can play an important role in explaining what happened and why.
159. To address this apparent gap in services locally, we recommend that the CCGs and the Trust put in place appropriate and clear processes to avoid such a situation occurring in the future. This should include providing training for service providers so that they have the necessary knowledge and expertise to deliver the services that are needed. The processes should be published so that families can easily access the support they require in such difficult circumstances.

The need for thorough and prompt investigations into serious incidents

160. This case clearly highlights the importance of urgent and effective investigations into serious incidents. This case also demonstrates that the NHS organisations involved did not have the ability to undertake what was immediately required, a thorough and prompt root cause analysis. Sadly, it seems that the only people involved in the case who recognised this were Mr and Mrs Morrish. Yet they were faced with obstacles at seemingly every turn when they asked for an independent and holistic investigation into the events that took place.
161. Despite what the PCT said at the outset about a '*joined-up*' approach and wanting to ensure the family were at the centre of the investigation, the outcome was very different. In fact, when it began the first investigation, the PCT was not aware

of all of the NHS organisations that were involved. Crucially, it had also not spoken to Mr and Mrs Morrish. In its investigation, the PCT did not seek to identify, and therefore did not succeed in identifying, the root causes of the events that led to Sam's death.

162. Mr and Mrs Morrish have been consistent in saying that what they wanted from an investigation of their son's death was an accurate account of what had happened and for the people involved to be held accountable for their actions. They had every right to expect that. Sadly, this is no longer possible. As we have noted in our report, in some areas of Sam's care there are several explanations of what went wrong. There are also gaps in those explanations. Given the time that has passed since the events, we do not think those gaps will ever be filled. This is a further significant injustice for Mr and Mrs Morrish because it is clear that some of their questions about what happened to their son will never be answered.
163. This clearly demonstrates how important it is to investigate incidents such as this as quickly as possible. Had a thorough root cause analysis been conducted in early January or February 2011, the evidence available would have been clearer and people's recollections would have been more recent (and therefore more accurate). Had this happened, it is likely that Mr and Mrs Morrish would have had some of the answers to the questions that remain.
164. It is clear that at the time of these events, the PCT and local NHS organisations did not have a systemic methodology for conducting a root cause analysis into the circumstances surrounding Sam's death. We recommend that the CCGs identify such a methodology and ensure that, within three months, there are people at the

organisation trained in that methodology who can use it effectively when they investigate serious incidents. NHS England should oversee this with a view to disseminating the learning from this case across the wider NHS.

Final remarks

165. This is our final adjudication on Mr and Mrs Morrish's complaints about the Surgery, NHS Direct, Devon Doctors Ltd, the Trust and the PCT. We are confident that the findings we have made are robust and accurate.
166. Sam died when he should have survived. This has had a devastating impact on Mr and Mrs Morrish and their family. Their distress was subsequently compounded by a lack of bereavement support. The family were left unsupported and had to actively seek the help for themselves and their other son that should have been offered to them.
167. Mr and Mrs Morrish have given us a great deal of valuable information as part of our work on their complaint, particularly in response to the draft reports we have shared with them. We have worked hard to ensure that our report achieves what they have always asked for, an accurate picture of the events that took place.
168. However, as we have said, because of the failure of the organisations involved to quickly and robustly investigate the circumstances surrounding Sam's death, Mr and Mrs Morrish are left with unanswered questions about what happened and why. This will continue to cause the family significant distress.

Recommendations

169. In making recommendations we are guided by our Principles for Remedy. ‘Putting things right’ states that where maladministration or poor service has led to injustice or hardship, public organisations should offer a remedy that returns the complainant to the position they would otherwise have been in. If that is not possible, the remedy should compensate them appropriately. Public organisations should consider fully and seriously all forms of remedy including an apology, remedial action and financial compensation.

The family

170. We recommend that within one month of the date of the final report, the Surgery, NHS Direct, Devon Doctors Ltd, and the Trust should each write to Mr and Mrs Morrish to acknowledge and apologise for the service failure and maladministration identified in this report and the injustice they have suffered as a consequence.
171. We also recommend that the Chief Executive of NHS England should write to Mr and Mrs Morrish to apologise for the failure of the system in relation to their son’s care.
172. We further recommend that NHS England should make a payment of £20,000 to Mr and Mrs Morrish. We recommend this is made in recognition of the opportunities the NHS missed to save Sam’s life, the injustice that this knowledge will continue to cause Mr and Mrs Morrish and the opportunities that the NHS missed to

- properly investigate the circumstances surrounding Sam’s death. This payment should be made within one month of our final report.
173. When we shared our draft recommendations with the family they queried how the payment of the compensation would be split. We believe that this case demonstrates that the whole NHS failed Sam and his family. This is why the recommendation is that the NHS makes the payment.
174. We also recommend that within two months of this report:
- the First GP and Second GP at the Surgery, and the paediatric consultant should meet their appraisers to discuss the findings of this upheld complaint. The doctors should ensure that the outcome of their meetings is sent to their responsible officer.⁸
 - The NHS Direct nurse adviser should also meet her supervisor to discuss the findings of this upheld complaint .
 - The individual clinicians should write to Mr and Mrs Morrish to confirm that this action has been taken.

Action to address service failures identified locally

175. Within three months of this report, the Surgery, NHS Direct, Devon Doctors Ltd and the Trust should prepare an action plan that describes what they have done, and what they will do, to ensure that they have learnt lessons arising from this upheld complaint, and what they have done and what they will do to prevent a

recurrence of the service failures we have identified. They should also explain how any improvements will be measured.

176. In particular:

- the Surgery (working with the CCGs) should have ensured that guidance is in place to assist reception staff in directing patients through the system of telephone triage. This should be published so that patients and staff know what to expect and what is expected of them.
- NHS England should review the sets of questions that call handlers on the 111 service are instructed to ask in order to assure themselves, and us, that adequate safety nets are in place in emergent situations.
- NHS England should review the guidelines in place for contingency plans in relation to out-of-hours services and ensure that it is a specific requirement that NHS organisations demonstrate that their contingency plans are regularly tested and their strengths and weaknesses identified and addressed.
- the CCGs and the Trust should put in place appropriate and clear processes for providing appropriate bereavement services to families in similar situations to that of Mr and Mrs Morrish, including providing training for staff so that they have the necessary knowledge and expertise to provide the services that are required. The processes should be published so that families like the Morrishes can easily access the support they require in such difficult circumstances; and

- the CCGs identify a methodology for conducting root cause analysis investigations when serious incidents have occurred and ensure that, within three months, there are people at the organisation trained in that methodology and using it effectively when investigating serious incidents. This should be overseen by NHS England with a view to disseminating the learning from this case across the wider NHS.
177. All the organisations should ensure that Mr and Mrs Morrish, the commissioning organisations and the Care Quality Commission, are updated on the actions being taken. The Trust should also ensure that Mr and Mrs Morrish are kept updated.
178. All the organisations should write to us to confirm that these actions have been taken, and provide us with copies of the relevant letters and action plans.

⁸ Each doctor has a responsible officer, who makes a recommendation to the GMC, usually every five years, about whether that doctor should be revalidated.

Annex A: The Chronology

1. A couple of weeks before Christmas 2010,⁹ the Morrish family caught flu. The Morrish family have told us that Sam’s flu was worse than everyone else’s but that this was apparently normal for him as he had a history of respiratory tract infections.¹⁰ Mrs Morrish gave Sam Calpol¹¹ and ibuprofen,¹² but says he appeared to get worse.

The Surgery

2. Mrs Morrish took Sam to the Surgery on 21 December and saw the First GP. In addition to flu symptoms, Mrs Morrish says she told the First GP that Sam had stomach pain, had vomited twice the previous night and had a very high temperature of about 39 degrees. Mrs Morrish was concerned that he might have a chest infection. The First GP noted that Sam had a ‘flu like illness’ and had had a high temperature for a week along with a cough and a rash. He listened to Sam’s chest and recorded that it was clear. The First GP did not record Sam’s heart rate, breathing rate or whether he was dehydrated. (There is no record of the GP having conducted a capillary refill test.)³ The First GP prescribed antibiotics for Sam. The First GP said in a subsequent

- statement that he told Mrs Morrish to give Sam the antibiotics if his condition worsened and she was unable to make it back to the Surgery (either due to the icy weather at the time, or the Christmas holidays). This is not recorded in the notes. Mrs Morrish told us that the First GP explained to her that she should bring Sam back to the Surgery if his condition worsened.
3. The following morning Mrs Morrish said she was very worried about Sam’s condition which she described as very lethargic, refusing to eat and very thirsty. Even though Sam was toilet trained, Mrs Morrish put him in a nappy because he was sleepy and she wanted to prevent him having an accident. Mrs Morrish told us that although Sam was more poorly than before, his temperature had lowered. She telephoned the Surgery at about 10.45am for advice.
 4. A nurse practitioner¹⁴ rang Mrs Morrish back at about 1.50pm and carried out a telephone triage.¹⁵ The nurse practitioner recorded that Sam’s condition was worse; he had no energy, was lethargic (Mrs Morrish describes Sam as being ‘*here but not here*’) and did not improve after he was given ibuprofen and Calpol.
 5. The nurse practitioner passed the information to another GP at the Surgery

(the Second GP), who called Mrs Morrish at about 2pm and organised an appointment for Sam at 4.10pm that afternoon. (There is no record of this call in the Second GP’s notes.) Mrs Morrish has told us that the Second GP did not show any sense of urgency on the telephone, and she felt reassured by the ‘*lack of panic*’.

6. Mrs Morrish attended the Surgery and waited between 20 and 30 minutes before she and Sam saw the Second GP at 4.30pm. Mrs Morrish told us that during this period, she felt increasingly anxious about Sam, who was so exhausted he was falling asleep on her lap. Mrs Morrish said that when she saw the Second GP, she tried to explain how much worse Sam had become over the last 24 hours. The Second GP recorded that Sam was still unwell, had a blanching rash¹⁶ (which meant it was unlikely Sam had meningitis)¹⁷ but was awake, communicating and had a clear chest. Although the Second GP noted that Sam’s level of hydration was ‘OK’, there is nothing in the records to show how the Second GP observed this. The Second GP noted that Sam’s respiratory rate was also ‘OK’, but there is no record of the actual rate. Mrs Morrish told us that the Second GP took Sam’s temperature but this was not recorded so we do not know the measure. Mrs Morrish told us that the Second GP asked whether Sam was urinating, and she told him that Sam had been in a nappy since that morning. The Second GP did not check Sam’s nappy to see if he had passed

any urine. The Second GP concluded that Sam had a viral infection¹⁸ because he could not find any other causes for his symptoms. Mrs Morrish said that the Second GP told her that ‘*the best place for Sam is at home*’, and he was sent home with a prescription for cough medicine. Mrs Morrish said she did not feel reassured by the Second GP and did not know what to do if Sam’s condition became worse.

7. After arriving home, at about 6pm, Sam vomited. Mrs Morrish said the vomit appeared to be clear but with ‘*tiny black streaks*’, which she thought might be blood. Mrs Morrish described Sam as having an intense thirst and he would not stop drinking, and the ‘*alarm bells started ringing*’. Mrs Morrish telephoned the Surgery immediately. A recorded message said the Surgery was closed. Mrs Morrish called NHS Direct because she was in a hurry to obtain medical treatment for Sam.

NHS Direct

8. We have listened to recordings of the conversations between Mrs Morrish and NHS Direct. Mrs Morrish called NHS Direct at 6.20pm and spoke to a health adviser.¹⁹ Mrs Morrish said that Sam had been seen by GPs the day before and that afternoon, and had been diagnosed with viral flu. She said that Sam had just vomited although he had only eaten half a Weetabix that day. She said that the vomit had ‘*lots of dark brown blobs in it*’. The health adviser

⁹ At this time, there was a flu epidemic and there had been severe weather conditions, including warnings of snow and ice.

¹⁰ An infection of the lungs that can cause shortness of breath, weakness, coughing, fever and fatigue.

¹¹ A children’s medicine, the main ingredient of which is paracetamol. It is used to treat fever and pain.

¹² A non-steroidal anti-inflammatory drug used to manage pain, fever and swelling.

¹³ A capillary refill test measures the time taken to refill the very small blood vessels in the body. It is used to measure whether someone is dehydrated. A refill time of less than three seconds is considered normal, whereas a time greater than this indicates increasing degrees of dehydration.

¹⁴ A nurse who has completed additional training beyond that of a registered nurse.

¹⁵ A method of determining how urgently a patient needs treatment based on their symptoms and conditions.

¹⁶ A rash that disappears when pressure is applied to the skin.

¹⁷ Inflammation of the protective membrane covering the brain and spinal cord. Meningitis can be caused by a viral or bacterial infection and can be life-threatening.

¹⁸ Viral and bacterial infections can cause similar symptoms, but viral infections are caused by a virus and usually involve many different parts of the body, whereas bacterial infections are caused by bacteria and mainly involve localised pain in a specific part of the body.

¹⁹ A non-clinical member of NHS Direct staff who directs calls from the public to the appropriate person or organisation.

felt that the symptoms required a clinical assessment. The health adviser took some details from Mrs Morrish and asked her a series of questions, one of which included '[has Sam] vomited anything other than milk or food?'. She recorded that Mrs Morrish said 'yes' to this question. The health adviser summarised the reason for the call as 'vomiting brown lumps [in past five minutes]' and transferred the call to an NHS Direct nurse adviser at 6.25pm.

9. The NHS Direct nurse adviser asked Mrs Morrish whether Sam had been vomiting and whether this was his main symptom. Mrs Morrish said that Sam had been vomiting clear fluid with darker brown lumps in it and she was concerned this might be blood. The NHS Direct nurse adviser selected the algorithm²⁰ 'vomiting, toddler (age 1-4 years)' to assess Sam and told Mrs Morrish that she would 'just go through a few questions with you regarding the symptoms and then I will give you some advice'.
10. The NHS Direct nurse adviser recorded 'no' to questions about whether Sam was 'floppy without muscle tone', 'unresponsive', 'could not be roused' or 'had cold and clammy skin'. Mrs Morrish told the NHS Direct nurse adviser that Sam was asleep, but the NHS Direct nurse adviser did not ask if she could wake him. The NHS Direct nurse adviser recorded 'no' to the questions about meningitis. She did not record that Sam was sleepy or had viral flu. The NHS Direct nurse adviser asked whether Sam had a rash. Mrs Morrish said that a GP had described Sam as having a viral rash. The nurse did not ask (as set out in the algorithm) whether Sam had 'tiny red pinprick spots', 'bluish discolouration

of the skin' or spots which looked like 'flea bites'. She recorded that Sam had 'none of the above'.

11. Mrs Morrish described Sam as having vomited brown lumps that were like dark strands and were 'glutinous'. She asked the NHS Direct nurse adviser whether this was blood. The NHS Direct nurse adviser said that the usual indication of blood in vomit was the presence of 'coffee ground' type material. Mrs Morrish said that there were long 'glutinous strands' that could be described as coffee colour. The NHS Direct nurse adviser told Mrs Morrish that because Sam had only vomited once that day, and as his vomit was not completely brown, she was not too concerned. The NHS Direct nurse adviser said that if Sam vomited brown lumps again, Mrs Morrish should contact her GP or NHS Direct.
12. The NHS Direct nurse adviser asked Mrs Morrish how much Sam had been drinking and whether he had been urinating normally. Mrs Morrish said that Sam was thirstier than usual and had been drinking a lot. She said that she had put a nappy on him mid morning and it was still dry. She said that the GP had not checked Sam's nappy at the last appointment. Mrs Morrish said that Sam felt hot, his breathing was faster and more shallow than usual, his tongue was very red and his lips were very dry. She said that Sam's condition was similar to when he had seen the GP about two hours ago, but he was now paler. She added that his penis hurt and he did not want to urinate.
13. The NHS Direct nurse adviser took the name of Sam's usual GP and asked Mrs Morrish how she felt about Sam seeing

an emergency (out-of-hours) doctor. Mrs Morrish said she was concerned about the lack of urine in Sam's nappy and the NHS Direct nurse adviser told her that she should mention this to the GP. The NHS Direct nurse adviser added that she would transfer Sam's details electronically to the out-of-hours doctor who would call the family, but that Mrs Morrish should call NHS Direct again if Sam's condition deteriorated. She told Mrs Morrish to give Sam fluids and to monitor whether he was passing urine. The NHS Direct nurse adviser closed the call at 6.42pm, and recorded a recommendation that Sam should be referred to 'Primary Care Service Same Day'.

14. Mrs Morrish has told us that after speaking to the NHS Direct nurse adviser, she had the impression that something was seriously wrong with Sam. She said she still had not been told to take Sam anywhere and was left waiting for a doctor to call but she did not know when this would be.

Devon Doctors Ltd

15. Devon Doctors Ltd, the out-of-hours GP service, received an electronic record of Mrs Morrish's call to NHS Direct at 6.44pm. The record stated that Sam's condition was 'vomiting brown lumps', and a clinical summary highlighted that Sam 'has not passed urine since this morning'. The 'Primary Care Service Same Day' referral was marked as a non-urgent (this type of referral requires a response from an out of hours GP within six hours). The referral was passed to Devon Doctors Ltd's Newton Abbot Treatment Centre (the Treatment Centre)²¹ at 6.48pm. The unit was staffed by one GP until a second doctor arrived at 7pm.

16. A GP at the Treatment Centre called Mr and Mrs Morrish at 7.12pm, but there was no answer. Mrs Morrish said that she remembers her telephone ringing, but she was attending to her other son and unable to answer the call in time. She dialled 1471 to find out who had called but the number had been withheld so she did not know who had tried to contact her. Mrs Morrish said that she thought that if the doctor had called, they would call back again shortly. Mrs Morrish said that when no one called, she found the number for the out-of-hours doctor in their area (Devon Doctors Ltd). She telephoned them at 8.52pm. We have read a transcript of the conversations Mrs Morrish had with staff at Devon Doctors Ltd, and the internal telephone calls between staff. The following information is taken from this transcript. Mrs Morrish spoke to a call handler from Devon Doctors Ltd and asked whether she had missed a call from them. The call handler then contacted the Treatment Centre to say that Mrs Morrish had rung because she thought she had missed a call from a GP. Mrs Morrish's call at 8.52pm was not logged by Devon Doctors Ltd.
17. Mrs Morrish spoke to a call handler again at 9.08pm and told them that Sam had just vomited black liquid. The call handler asked whether Sam had eaten anything black. Mrs Morrish said that Sam had not eaten anything all day. The call handler took her details (name and address) and (as if reading out aloud) said 'waiting for clinician/doctor's advice, vomiting brown lumps'. Mrs Morrish said that Sam had previously vomited brown lumps in a clear liquid, but what he had just vomited was 'completely black'. Mrs Morrish told us that the call handler asked her if she wanted to

²⁰ An NHS Direct algorithm is a set of clinical questions that assists the nurse to identify the level of care required based on the presenting symptoms at the time. The algorithm is designed to question the most severe clinical symptoms first. The algorithm does not replace the skills and experience of the nurse conducting the assessment.

²¹ Out-of-hours GPs and a minor injury unit were located at the treatment centre.

go to the Treatment Centre, to which she replied *'if they've got suitable treatment'*. The call handler appeared to be unsure where to send her and Sam. Mrs Morrish said that whilst she knew the local hospital in Torbay had the facilities of a *'proper hospital'* she was unsure whether the Treatment Centre did. She said she did not want to drive there only to be told to go to the hospital. The call handler agreed to find out where would be best to send Sam.

18. At 9.13pm the call handler contacted the Treatment Centre and spoke to a member of staff (a driver who was not clinically trained). The call handler explained that Mrs Morrish had told him that her son had been vomiting brown lumps and black fluid and she wanted to know whether to go to the Treatment Centre or the hospital. The call handler said that Mrs Morrish wanted to go to somewhere with appropriate facilities. The driver at the Treatment Centre said that whilst he did not know what equipment was at both sites, they had the same type of doctors and the Treatment Centre was *'just around the corner from [Mrs Morrish]'*. The call handler said that Mrs Morrish thought that her son might need to be admitted to hospital and did not want to go to the Treatment Centre if she was going to have to go somewhere else. The driver at the Treatment Centre said that:

'I can't say that [Sam would be admitted to hospital] or not but if he was admitted then it would be [to the Trust's hospital]. But does [Mrs Morrish] really want to go to [the Trust's hospital] on the off chance of an admission? I mean to get to [the Trust's hospital] she'd have to virtually go past [the Treatment Centre] anyway.'

...

'...it's not as though she's going in two different directions if she does come here and if the doctor wants to admit the patient then yes she'll be sent to [the Trust's hospital]. But she's got to come past this door anyway.'

19. The call handler contacted Mrs Morrish at 9.17pm and told her that:

'[the Treatment Centre] said that whilst the symptoms do need to be reviewed today, there's no guarantee that the child is going to be admitted. So if you were to go to our treatment centre ... they have the same facilities in Newton Abbot and [the Trust's hospital]. If you were to go to A&E then there's again a chance that you're going to be sent through to our treatment centre and then you'll be in the same loop again.'
20. The call handler did not tell Mrs Morrish that he had been unable to speak to a clinician or anyone with medical training.
21. Mrs Morrish queried whether she should go to the Treatment Centre or to the hospital. The call handler said she should go to the Treatment Centre and that he would *'adjust the case details for you to go to Newton Abbot and have them expect you to arrive'*. The call handler took Mrs Morrish's mobile phone number and said he would *'let Newton Abbot know'*. The call handler contacted the Treatment Centre and told them that Mrs Morrish was on her way. The call handler did not update the computer records to record that Sam had vomited black liquid. At 9.19pm, a GP at the Treatment Centre attempted to call Mrs Morrish, but the telephone line was engaged.
22. Mrs Morrish arrived at the Treatment Centre with Sam at 9.38pm. Two doctors would usually be on duty. When Mrs Morrish arrived with Sam, one GP

was attending to another patient in the community and the other doctor was dealing with a young child who was very seriously ill and had collapsed at the Treatment Centre. Mrs Morrish said that there was a queue of people at the Treatment Centre, and when she saw the receptionist, she was told that there were three people waiting to see the doctors before her, and she would have to wait her turn. Mrs Morrish said she queried this statement at the time because she thought the the Treatment Centre had been told that Sam's case was urgent. Mrs Morrish told us that despite Sam's condition being much worse, and that his pyjamas were covered in blood from vomiting, reception staff showed no sense of urgency.

23. At 9.55pm, a minor injury unit nurse walked past Sam, and Mrs Morrish alerted her to her son's condition. The nurse took Sam into a resuscitation room for assessment where he was seen by a GP. The GP reviewed Sam and immediately contacted the emergency services and requested an ambulance. The emergency call handler recorded that Sam was *'extremely dehydrated, compromised breathing fast, very pale'*. The GP confirmed that Sam's condition presented *'an immediate threat to [his] life'* and he needed to go to A&E at the Trust. The GP also called the paediatric team at the Trust to inform them that Sam was on his way, that he had been *'vomiting coffee grounds'*, was very unwell, his respiratory rate was over 40 breaths per

minute²² and his heart rate was 171 beats per minute.²³ He said that Sam's capillary refill was three to four seconds (indicating he was slightly dehydrated) and he was very pale. The paediatric team at the Trust agreed to the GP's request that Sam should be seen in the resuscitation area.²⁴ An ambulance happened to be driving past the Treatment Centre at the time the GP made the 999 call and arrived to collect Sam almost immediately.

The Trust

24. Sam arrived at the Trust's A&E department at approximately 10.30pm. An initial assessment established that he was short of breath, pale and looked like he had vomited blood on his pyjamas. He also had a blanching rash. Records show that Sam's respiratory rate was very high (40 breaths per minute), he had low oxygen saturation (92%)²⁵ (which can be caused by such conditions as pneumonia), a fast heart rate (140 beats per minute) and a high temperature (38.5 degrees).²⁶ The records also show his urine output was low and he was eating much less than usual. A paediatric registrar reviewed Sam (it is not clear from the records exactly when, but it was before 11.10pm when Sam was reviewed by a surgical registrar),²⁷ and recorded that he had vomited *'coffee grounds'* that afternoon, had had flu-like symptoms for about a week, and his condition had deteriorated over that time. His capillary refill time was six seconds (demonstrating

²² Normal breathing rate is between 20 and 30 breaths per minute.

²³ Normal resting heart rate for children aged three is between 90 and 140 beats per minute.

²⁴ A department in a hospital that specialises in the care of patients who have suddenly become unwell.

²⁵ Oxygen saturations refer to the amount of oxygen in the blood. A child in good health should have an oxygen saturation level of between 95% and 100%.

²⁶ Normal temperature for a child is about 36.4 degrees.

²⁷ The paediatric registrar told us that he saw Sam as soon as A&E staff told him of his arrival.

that he was dehydrated, and also indicating that he was in shock).²⁸ The paediatric registrar also noted that Sam's right lung had a lower than normal amount of air in it, and his stomach was '*moderately resisting palpation*,²⁹ *bowel sounds present*'.³⁰ He recorded that Sam might have pneumonia or '*abdominal pathology*' (a problem in his abdomen). The paediatric registrar recorded that Sam should be given oxygen and have a chest X-ray, and prescribed (antibiotics) intravenous ceftriaxone³¹ and ranitidine.³² A prescription was written sometime between 10.30pm and 11pm. The paediatric registrar also ordered blood tests. These showed that Sam had a low white blood cell count but high C-reactive protein levels (indicative of a significant bacterial infection), and his sodium, potassium, creatinine and urea levels were within normal limits (indicating that his kidneys were not, at that stage, failing).³³ The paediatric registrar recorded that Sam should be given a fluid bolus³⁴ (20mls/kg body weight – which was given at 11.15pm). The level of carbon dioxide in Sam's blood was within normal limits, but his blood lactate levels were higher than normal.³⁵ The paediatric registrar discussed

Sam's symptoms over the telephone with an on-call paediatric consultant (who was at home). They decided that Sam should be given fluid resuscitation,³⁶ his condition should be monitored, and the paediatric registrar should seek advice from a member of the surgical team. The paediatric consultant arrived at the hospital within 10 minutes of the telephone conversation with the paediatric registrar.

25. A surgical registrar reviewed Sam at 11.10pm and agreed with the plan to manage his condition. He noted that the intensive care unit had been told about Sam and were to come and see him. He did not consider that Sam had a major problem with his abdomen. Further observations were taken at 11.20pm, which showed that Sam's blood pressure was 108/50 (normal)³⁷, his heart rate was 145 beats per minute and his respiratory rate was 60 breaths per minute. Sam received a further fluid bolus at 11.50pm (10mls/kg body weight).
26. Mr Morrish told us that he was concerned about a comment the paediatric consultant made during this period about his changing from full-time to part-time

hours, which had the benefit of him not having to be on call. The paediatric consultant confirmed to us that he said this. He said he had not intended to be insensitive and apologised. Mr Morrish also told us that while in A&E, he overheard staff discussing Sam's care, in particular that they considered the Second GP had been wrong to send Sam home earlier that afternoon because they felt that Sam had '*signs of illness when he was examined*'. Mr Morrish has said that:

'it is entirely possible that, whilst right in some areas, A&E staff made other "wrong assumptions" based on the fact that they thought the Second GP had missed Sam's lungs. It is possible that Sam's lungs sounded clear at 4.30pm ... the implication being that Sam was deteriorating quickly.'

27. Sam was reviewed by a registrar from the intensive treatment unit at 12.15am; the paediatric consultant was also there but there is no written note from him at this time. The registrar noted that Sam's chest X-ray indicated that he had pneumonia, and that he should be transferred to the paediatric high dependency unit. He also noted that Sam had been prescribed oxygen and antibiotics. The paediatric consultant discussed how to manage Sam's condition and left the hospital to go home. At 12.20am, Sam's observations showed that his heart rate was 150 beats per minute, his respiratory rate was 36 breaths per minute, and his oxygen saturation was 96%. Nurses did not take Sam's temperature or his blood pressure. Sam arrived in the high dependency unit at approximately 12.45pm. During his stay in A&E, Sam was not given the prescribed antibiotics or ranitidine, nor were his

paediatric early warning scores calculated. Mrs Morrish told us that the X-ray showed that one of Sam's lungs was completely white. She said that she spoke to a doctor who told her that if the GPs at the Surgery had properly assessed Sam's lungs at the time, he would not have been sent home.

28. Mrs Morrish told us that the doctors had discussed with her where to send Sam (the high dependency unit or the intensive treatment unit). She said that she felt the high dependency unit would be a less '*scary*' environment for Sam, but that this was a decision for doctors to take, not her. Mr Morrish told us that after Sam was transferred, the behaviour of staff did not cause any 'alarm bells'. Mr Morrish said as he thought that Sam was stable, he felt he could go home to look after their other son.
29. The paediatric consultant told us that he was responsible for Sam's care, and for the decision to send him to the high dependency unit rather than the intensive treatment unit. He said that at the time the decision was made, Sam was alert and responsive, and the high dependency unit was the most appropriate place for him to be.
30. At 1am, it was noted that Sam's temperature was still high (38 degrees), his respiratory rate was very fast (72 breaths per minute) and he was in severe respiratory distress.³⁸ His oxygen saturation was low (90 to 93%). Nurses recorded a paediatric early warning score of four and requested that doctors reviewed Sam in 30 minutes. Mr Morrish describes that before he left to go home Sam had a '*blank look on his face*'. He said that saying goodbye to his son was hard because '*it seemed as if he was looking through me*'.

28 When a patient is in shock, blood flow moves away from the extremities towards the body's vital organs. As a consequence, a patient's capillary refill time is prolonged.

29 Sam's stomach was becoming tense when touched, which might have indicated he was in pain.

30 The presence of bowel sounds usually indicates that food is passing through the digestive system normally.

31 A broad-spectrum antibiotic, often used to treat pneumonia and bacterial meningitis, and, in young children, to manage sepsis.

32 A drug that reduces the production of stomach acid.

33 These levels rise (especially creatinine and urea) if the kidneys are failing.

34 A process whereby fluids are rapidly delivered directly into a patient's vein in order to correct a life-threatening condition.

35 Lactic acid levels get higher when certain conditions, such as sepsis or shock, lower the flow of blood and oxygen throughout the body.

36 The replacement of bodily fluids, usually given via the vein, the mouth or rectally.

37 The normal blood pressure range for young children is between 80 to 120/34 to 75.

38 A life-threatening reaction to an acute infection of the lungs. Severe respiratory distress can cause inflammation in the lungs leading to reduced gas exchange, reduced oxygen in the blood, and multiple organ failure.

I thought it was just because he was so tired; he had been awake for hours when he should have been fast asleep’.

31. At 1.30am a nurse gave Sam the antibiotics that had been prescribed earlier and recorded his blood pressure (125/66). In a subsequent statement, the nurse said that she was concerned about Sam’s condition (he still had a paediatric early warning score of four), had thought he was in shock and had called the paediatric registrar. At 1.39am, further tests showed that although Sam had been given oxygen, and his breathing rate had increased, the amount of carbon dioxide in his blood was rising (when it should have been falling). The paediatric registrar saw Sam 15 minutes later,³⁹ noted that he had a very high C-reactive protein⁴⁰ level, had fast breathing and heart rates, and low oxygen saturation. Sam’s capillary refill time had decreased to three seconds (suggesting he was less dehydrated than before). The paediatric registrar felt that Sam was in ‘*impending septic shock, may need [intensive treatment unit] observation*’.
32. At 1.45am, the paediatric registrar discussed Sam’s condition with the paediatric consultant over the phone. The paediatric consultant advised him to give Sam two further fluid boluses and said that

observations should continue. Sam was given ‘*maintenance*’ fluids intravenously at 1.50am, (not the boluses – maintenance fluid is given purely for the purposes of maintaining fluids at the current level).⁴¹ At 2am, Sam’s paediatric early warning score was five. At 2.10am a senior house officer from the intensive treatment unit was called to the high dependency unit because Sam’s respiratory rate had increased to 80 breaths per minute and his capillary refill time was six seconds. Sam was given the fluid boluses at 2.20am and 2.40am. During this time, his blood pressure had fallen and was 103/78. He was also given salbutamol⁴² at 2.50am to see if this would help his breathing.

33. At 3am, Sam’s respiratory rate was noted to have lowered to 40 breaths per minute and his capillary refill time had improved to four seconds. An anaesthetist consultant saw Sam and said he should be monitored and reviewed again in an hour, or sooner if his condition deteriorated.⁴³ The records show that the anaesthetist consultant discussed Sam’s condition with the paediatric consultant (over the phone) and an intensive care consultant. There is no evidence that the paediatric consultant or the intensive care consultant reviewed Sam in person. Mrs Morrish told us that Sam was agitated, adding that nurses

described Sam’s agitation as a good sign and it showed he was ‘*fighting*’. However, Mrs Morrish said she later found out that agitation was a sign Sam had sepsis. He had a rash around his groin. She was concerned about her son’s condition and contacted her husband to tell him to return to hospital. Mrs Morrish describes that at the time, Sam was bleeding from his mouth (there were bubbles in his blood). She added that as Sam’s temperature was high, nurses took his shirt off and eventually his nappy. Mr Morrish arrived at hospital, and Sam was sitting in his mother’s lap.

34. At approximately 3.20am, a nurse spoke to the paediatric registrar about asking the paediatric consultant to return to hospital. The paediatric registrar telephoned the paediatric consultant to inform him of Sam’s condition. The paediatric registrar spoke to the paediatric intensive care unit at another hospital trust at approximately 3.30am and was advised to try and stabilise Sam and to contact them later. During this conversation, Sam stopped breathing. At 3.40am, Sam was ‘*moribund*’ (he had a reduced level of consciousness), had a large amount of blood coming up through his mouth and nose, and doctors could not feel a pulse. The paediatric consultant arrived at about 4am while doctors were performing cardiopulmonary resuscitation.⁴⁴ Sam died shortly after 5am.

35. The paediatric consultant told us that because Sam had died within 24 hours of being admitted to hospital, he spoke to the coroner’s office when it opened later that morning.⁴⁵ He told us that he had not reviewed Sam’s medical records before speaking to the coroner because at the time, he was involved in Sam’s care and felt he knew what had happened.
36. The PCT was told of Sam’s death the same day, as was the public health nurse team.⁴⁶ Blood test results available after Sam died showed that he had group A streptococcal infection⁴⁷ and the flu virus. Later that day, Sam’s grandmother contacted the Surgery to request sleeping pills for the family.
37. The following day, the Trust’s bereavement officer contacted the Surgery to tell them about Sam’s death. The Trust also gave Mr and Mrs Morrish contact details for their bereavement office. The Health Protection Agency⁴⁸ contacted the Surgery to say that tests had shown that Sam had ‘*invasive group strep A*’, which might have either been the main cause of infection, or the consequence of another infection, and a doctor should contact the family to tell them to seek advice or antibiotics if they developed any symptoms. The Health Protection Agency later contacted the Surgery (in March 2011) to provide advice on how to treat patients ‘*co-infected*’ with flu and streptococcal A infections.

39 The paediatric registrar told us that he did ‘not recall a delay in assessing Sam. However, I agree that exact timings might be difficult to verify’.

40 A protein found in the blood, the levels of which rise in response to inflammation. Usual levels are less than 10mg/l. Sam’s was 442mg/l.

41 The paediatric registrar told us that he was concerned about giving Sam further fluid boluses because he was in shock and had already needed several fluid boluses. He felt that Sam should be transferred to the intensive treatment unit, rather than just given boluses. He said he was aware that giving further fluids could further compromise Sam’s lungs, which were already affected by pneumonia, and he might need intubating and ventilating

42 Salbutamol works by opening up the air passages so that air can flow into the lungs more easily. It can help to relieve symptoms such as coughing, wheezing and shortness of breath..

43 The medical records for this time were written retrospectively. The consultant anaesthetist recorded that he reviewed Sam at 2.30am, the senior house officer recorded that this review took place at 3am

44 An emergency procedure to manually restore blood circulation and breathing.

45 The coroner’s court support services set out when a death should be reported to the coroner. This includes if the death occurs within 24 hours of admission to hospital (unless the admission is solely to provide terminal care). www.coronerscourtsupportservice.org.uk/faq-s

46 The public health nurse team was commissioned by the PCT to undertake checks on new born babies and preschool children, as well as provide advice to parents, including during periods of stress.

47 A bacterial infection that can cause a variety of conditions from very mild to life threatening diseases.

48 The Health Protection Agency facilitates an integrated approach to protecting public health in the UK through the provision of support and advice to the NHS.

38. On 30 December the paediatric consultant responsible for Sam's care in hospital shared preliminary post mortem findings with the Surgery. He said that the main findings were 'haemorrhagic oedatous and heavy lungs',⁴⁹ blood cultures had grown 'strep A', and other tests had shown that Sam had viral flu. The paediatric consultant told the Surgery that he had spoken to Mr and Mrs Morrish about the preliminary findings of the post mortem and would talk to them again in a couple of weeks to discuss any further questions they might have.

What the Surgery did next

39. On 4 January 2011 Mrs Morrish contacted the Surgery asking 'what the Practice [was] doing following the death of her son'. Mr Morrish also spoke to the GPs at the Surgery. The Surgery told Mr Morrish they would be undertaking a significant event review⁵⁰ into Sam's care, and there would be a meeting with all partners at the Surgery on 7 January. Mr Morrish says he wanted to know whether all the organisations involved in Sam's care would be involved in a review so that if the same things happened to his other son, he would 'come out ... in one piece'. The Surgery did not inform the other organisations involved about Mr and Mrs Morrish's concerns. They did not tell Mr and Mrs Morrish to whom they should direct their questions about the other organisations.

40. The Surgery held a meeting with their partners on 7 January, and produced an action plan. This plan included producing

a chronology of events; reviewing flu guidelines and establishing whether the Trust was undertaking a significant event review. The Surgery indicated that they also planned to speak to a consultant anaesthetist at the Trust to see if they would be willing to meet the family. There is no evidence that the Surgery spoke to a consultant anaesthetist. The Trust's Patient Advice and Liaison Service (PALS) contacted the Surgery for information about the family's concerns.

41. The Surgery obtained statements from the GPs involved in Sam's care. In his (undated) statement, the First GP said that he had seen Sam on 21 December. He said this was the first time he had met Sam and his family. In his statement, he said that Mr and Mrs Morrish were concerned because Sam had a fever, cough, and a rash, and was vomiting. He said that Sam was alert and friendly, although subdued, but it was easy to examine him. Sam had a fine rash on his chest that disappeared when pressure was applied. In his statement, the First GP said an examination of Sam's chest showed that he was taking air equally into both lungs, and there were no obvious abnormal noises to indicate pneumonia. The First GP said that although Sam's appetite was slightly reduced, he was drinking normally, and he felt that Sam might have flu. Due to the symptoms, and how close it was to Christmas, he prescribed 'delayed' amoxicillin (antibiotics) in case Sam developed 'symptoms suggestive of pneumonia' over the Christmas period. The First GP said that 'my advice at the time as I recall is that if Sam's symptoms

were to worsen that Mr and Mrs Morrish could use the antibiotics'. The First GP said that he was told, two days later, that Sam had died from an overwhelming infection. He said he was shocked, and questioned his consultation on 21 December. When he found out that Sam had died from a bacterial infection, he 'immediately regretted not having given the antibiotics I prescribed straight away'. He said he realised that Sam's 'death was the result of a rare and devastatingly sudden and overwhelming infection, but I am deeply sorry for the enduring loss Sam's family and community have experienced'.

42. In a statement taken on 24 January, the Second GP said that, after the nurse practitioner conducted her telephone triage, Sam's details were passed through to him and he called Mrs Morrish almost immediately. He said Mrs Morrish told him that Sam had deteriorated and he 'encouraged' her to bring Sam in for an appointment at 4.10pm. The Second GP said that when he saw Sam, he was obviously unwell, although his breathing rate was normal, his chest was clear and there were no signs of infection in his throat. He said he recorded that Sam had a 'blanching rash', which he felt was in keeping with a 'viral illness which had not progressed' since the previous day. He thought that Sam had a flu-type illness, but because there was no evidence of a bacterial infection, there was no need to give Sam antibiotics. He accepted that he would check the nappies of sick children in the future and that 'maybe this would have made the pendulum swing to admitting [Sam] to hospital, but we think this wouldn't have made any difference in the end'. The Second GP said that he told Mrs Morrish to obtain a further medical review (from the Surgery, or an out-of-hours doctor) if Sam's condition

deteriorated further. The Second GP said that after being told of Sam's death, he attended a meeting with the other GPs at the Surgery to discuss:

'how we should best respond to be as supportive as possible for Mr and Mrs Morrish, to properly assess the care we provided for Sam, and to ensure we manage future patients with flu-like symptoms to the best of our ability and in keeping with best clinical practice.'

43. A lead GP at the Surgery also provided a statement. He said that he received a call from the paediatric consultant at the Trust on 23 December telling him of Sam's death. He said that he also spoke to Sam's grandmother as she had asked for sedatives for Mr and Mrs Morrish. The lead GP explained that he spoke to the Health Protection Agency on 24 December, who advised offering the Morrish family flu vaccinations. The lead GP said that whilst he had not had direct contact with the family, there had been 'lengthy discussions' with the other partners at the Surgery 'as to how best to support the ... family'.

44. In January a nurse practitioner at the Surgery spoke to Mr and Mrs Morrish about them having flu vaccinations. Mr Morrish says he told the nurse that because of the circumstances surrounding the death of their son, his wife found it difficult to visit the Surgery, and she was in shock. On 17 January Mr Morrish contacted the Surgery because he wanted to meet and discuss what had happened. The same day, the family's allocated GP visited them at home. The allocated GP told us that during the visit she gave the family some literature, including a book about helping children cope with bereavement.

⁴⁹ Bloody fluid on the lungs.

⁵⁰ A review of cases in which a significant occurrence (not necessarily involving an undesirable outcome for the patient) is analysed to ascertain what can be learnt about the overall quality of care and to indicate whether changes should be made in the future.

Action by the PCT

45. The Surgery contacted the PCT by email after its meeting on 7 January for advice about how best to proceed with an investigation. The PCT acknowledged this email and asked the Surgery to provide details of any significant event review that was carried out.
46. On 10 January an internal email was circulated around the PCT asking if someone could contact the Surgery as it was keen to follow the correct procedures and wanted help to arrange a meeting with Mr and Mrs Morrish and the Trust. The PCT also contacted the Trust to say that the family wanted to meet to discuss the events surrounding Sam's death. The PCT asked the Trust to contact the Surgery to give them advice and, if the Trust had begun an investigation, *'perhaps [the investigations] could be joined-up'*.

What the Trust did next

47. Following Sam's death, the Trust obtained statements from three nurses involved in Sam's care. The Trust later obtained a statement from the paediatric registrar. In her statement, a nurse from the A&E department said that she was made aware that Sam would be arriving and prepared the resuscitation area. When Sam arrived he was pale, irritable, lethargic and thirsty. She noted that his pyjamas had *'coffee ground'* vomit on them. Her initial assessment suggested that Sam was in shock and she called the paediatric registrar. The A&E nurse said she left Sam for about 15 minutes, and when she returned, she was told that Sam had been given fluids and he had been reviewed by doctors from the intensive treatment unit and a paediatrician. She said that after Sam was given more fluids, he seemed

more alert. The A&E nurse said that Sam was *'booked out'* of A&E at 12.15am, and whilst he was waiting to be sent to the high dependency unit, she prepared his *'equipment'* to enable a safe transfer. As part of the handover to the high dependency unit team, the A&E nurse said, she told them Sam had not been given the antibiotics he had been prescribed. In her statement, she said that the doctors were aware of this, and the emphasis was on moving Sam to the high dependency unit and settling him in. The paediatric registrar told us that he was unaware that Sam had not been given antibiotics. He said that *'in hindsight, it would have been good practice if I had double checked if the antibiotics were given.'*

48. The statements of the high dependency unit nurses, and the A&E nurse, were taken within eight weeks of Sam's death. The first nurse said that when Sam was admitted to the unit at about 1am, she was concerned because he looked sick, was conscious but drowsy, and had fast breathing and heart rates. She helped another nurse give Sam the antibiotics (at 1.30am) and ranitidine that had been prescribed in A&E but not administered. She also gave him fluids and highlighted her concerns to a doctor. The nurse said that after Sam was given more fluids he seemed to *'perk up'* but was still agitated and was trying to pull off his oxygen mask. She said that Sam's temperature was very high, and he began bleeding from his mouth, so she called a paediatric registrar and an anaesthetic consultant. As Sam was still agitated, she placed him on his mother's lap and changed the bed sheets as they had blood on them. The high dependency unit nurse said that Sam seemed to calm down a bit at this stage, but then he became moribund and she was concerned about his breathing. She called an anaesthetist

again. The anaesthetist began *'bagging'*⁵¹ Sam while he was prepared for intubation.⁵² In the meantime, medical staff began full cardiopulmonary resuscitation. The high dependency unit nurse said that she stayed with Sam's parents during this period, and explained what was happening. She said that after Sam died, she stayed with the family whilst he was cleaned and moved to another cubicle. She said she took Mr and Mrs Morrish to see their son, and a priest arrived shortly afterwards to talk to them.

49. The second nurse said in her statement that she saw Sam at about 1.15am and her first job (along with the other high dependency unit nurse) was to give him the antibiotics *'that had not already been given'* and to commence *'maintenance fluids'*. She said that she checked Sam's capillary refill time at about 2am and found it was five seconds. She said she told the paediatric registrar who told her to give Sam a further fluid bolus, after which his capillary refill time dropped to four seconds (at 3am). The nurse said that the paediatric registrar told her not to give a further fluid bolus as *'he was aware we felt Sam should be in [the intensive treatment unit] and he was in contact with the paediatric consultant'*.⁵³ She said that a short time later, a consultant anaesthetist reviewed Sam, and he was given a further fluid bolus (at 2.40am), which appeared to make Sam *'brighter in himself'*. She said that at approximately 3.20am, she spoke to the paediatric registrar because she *'felt Sam was deteriorating and that [the*

paediatric consultant] *should come in and did he want to phone him or should I'*. The nurse said that the paediatric registrar rang the paediatric consultant and Sam was sitting in his mother's lap and was agitated. She said that during Sam's admission, she was in the intensive treatment unit and had spoken to the sister there to say that it was likely that Sam would be transferred to her care. However, on returning to the high dependency unit, she found that Sam had collapsed and resuscitation had begun. She said that she helped try to resuscitate Sam whilst the other high dependency unit nurse looked after Mr and Mrs Morrish.

50. The Trust held an internal review meeting on 11 January to discuss the care it had provided for Sam, and following that, conducted a root cause analysis⁵⁴ investigation into what had happened. The investigation report identified a number of issues, including that the paediatric consultant had gone home; the paediatric registrar was new to the post and it was his first week of working nights; a paediatric early warning score chart was available but not consistently used; there was no paediatric nurse on duty in A&E; and there was a delay in giving Sam the antibiotics he was prescribed in A&E. The *'lessons learned'* section of the investigation report stated that *'If [intravenous] antibiotics are prescribed they should be given as soon as possible in A&E. The doctor prescribing, and the nurse caring for the child, should ensure that these are given (memo sent)'*. A number of recommendations were

⁵¹ Bagging' refers to using a bag to deliver air to the lungs and so help a patient breathe.

⁵² When a patient is intubated, a flexible plastic tube is placed into the windpipe to maintain an open airway.

⁵³ The paediatric registrar told us that 'because Sam was in shock and had already needed several fluid boluses, I felt we should try and get Sam to the intensive treatment unit rather than just giving him boluses'.

⁵⁴ A root cause analysis is a tool to help identify how and why incidents happened, and to help prevent them from happening again.

made, which included that the Trust should investigate the *'possibility of using a paediatric early rapid response team to support adult trained nurses in A&E overnight'*. However, there was no analysis of the impact of any of the key issues identified. (The PCT shared a copy of the Trust's investigation report with Mr and Mrs Morrish on 14 June, and Mr Morrish sent a list of questions about the report to the Trust on 20 June.)

Mr and Mrs Morrish's meeting with the paediatric consultant

51. On 17 January the paediatric consultant met Mr and Mrs Morrish. A family friend, who worked at the PCT, took notes. The paediatric consultant told the family about the preliminary findings of the post mortem, which indicated that Sam had *'heavy lungs'*, or *'pneumonia by definition'*. Mr and Mrs Morrish questioned why, if this finding was true, had a GP from the Surgery told them Sam's chest was clear. The paediatric consultant said that an examination should involve a number of checks, and not just listening to the chest. He explained that doctors should also look for nasal flaring and whether the patient has to sit forward to breathe. He could not say what exactly the GPs had found, but said that the Surgery was conducting an internal investigation. The paediatric consultant also explained that streptococcal A is usually treated quite easily using penicillin. However, if a person's immune system is lowered (for example, because they have flu), a sore throat can

become septic, and septic shock can cause collapse (the failure of the body's internal systems).⁵⁵

52. The paediatric consultant said that the paediatric registrar called him at home and explained Sam's symptoms. He did not think that Sam's symptoms were related to his abdomen but that he had a problem with his lungs. The paediatric consultant thought that Sam had sepsis secondary to a lung infection, or vice versa. He explained that when people vomit, they can damage their stomach, and ranitidine was prescribed to help prevent erosion of the stomach lining caused by the vomiting. The paediatric consultant said that the *'coffee grounds'* present in Sam's vomit suggested that he might have had a bleed in his stomach, but this was not the primary problem.

53. The paediatric consultant said that after the death of any child, a significant event review is carried out. The review would look at what happened leading up to the death. It would not seek to apportion blame, but would find out if any *'part of the system went wrong'* and recommend action to prevent the same thing happening again. He said that staff at the Trust were very upset about what had happened, but they wanted the family to know that they did everything they could for Sam. Mr Morrish explained to us that the paediatric consultant said that staff at the Trust had been *'emotionally de-briefed'* following Sam's death. He told us that this contrasted with the lack of support his family experienced.

54. At the meeting, Mr and Mrs Morrish asked the paediatric consultant to talk through the sequence of events. The paediatric consultant explained that Sam had flu and was exposed to streptococcal A bacteria at some point, which finally became *'invasive'*⁵⁶ (he said probably 48 hours before Sam died). The infection would have spread to Sam's blood and to his lungs, leading to pneumonia, and he died of septic shock when the infection became too much for his body to cope with. The paediatric consultant speculated that Sam could have lost too much blood from his stomach causing his blood pressure to drop, but septic shock was the most likely reason for Sam's death.

55. The family asked whether Sam would have lived if he had been given antibiotics sooner. The paediatric consultant said, *'even if I could prove to you [that giving antibiotics] wouldn't have made any difference it will be difficult for you and the GP not to ask those questions'*. The paediatric consultant said that he had seen a child in a similar situation to Sam who had received antibiotics 24 hours earlier, yet he had still *'collapsed'*. Mr and Mrs Morrish told us that, during this meeting, the paediatric consultant suggested that there had been around a 90-minute delay in giving antibiotics (whereas the Trust's subsequent

investigation report indicated that the delay was almost three hours). There is no record of this statement in the notes of the meeting.

56. Mr and Mrs Morrish told the paediatric consultant that they were finding it hard to consider returning to the Surgery. They also raised concerns that the family all had different GPs and there might be no continuity of care, and explained they wanted *'help for [Sam's brother] in his relationships with doctors'*. The paediatric consultant said that his team was there to provide support, but it would help the family to meet the GPs to explain how they were feeling, and to have just one GP to look after them. The paediatric consultant explained that there were support groups that could help when a sibling dies, highlighting Winston's Wish.⁵⁷ The paediatric consultant said there was another organisation, but he could not remember the name of it. He said that if the family was struggling, he was there to help and would sit down with their friends and relatives to explain what had happened. He said that the family might experience flashbacks, but they could call him as often as they like. He ended the meeting by saying that the Trust would conduct a full inquiry,⁵⁸ which would involve the Surgery, and the findings would be anonymised and organised *'centrally'*.

⁵⁵ Mr Morrish told us that he had a number of meetings with the paediatric consultant who told him that streptococcal A infection is very rare, difficult to identify and difficult to treat. Mr Morrish has said that it should have been clear to doctors that, regardless of the rarity of streptococcal A infection, his son died of sepsis (caused by streptococcal A), which is easier to identify. He said that he felt that he was being given the wrong impression by the paediatric consultant and other doctors.

⁵⁶ Invasive streptococcal infections occur when the bacteria get past the natural defences of the person who is infected. This may occur when a person has sores or other breaks in the skin that allow the bacteria to get into the tissue, or when the person's ability to fight off the infection is diminished because of chronic illness or an illness that affects their immune system.

⁵⁷ Winston's Wish is a childhood bereavement charity that provides services to bereaved children, young people and their families in the UK.

⁵⁸ The paediatric consultant was referring to a child death review process, which reviews the deaths of children under the age of 18 years. This is a statutory process (under the remit of the local safeguarding board) by which unexpected child deaths are reviewed to establish whether there are any patterns or trends. The information is anonymised so that individuals cannot be identified. Mr Morrish told us that the child death review process is not an inquiry, and it was misleading of the paediatric consultant to label it as so.

Mr and Mrs Morrish's meeting with the Surgery

57. Mr and Mrs Morrish met staff from the Surgery (including the First GP and the Second GP) on 25 January 2011. The following information is taken from the minutes of this meeting. Mrs Morrish explained that although Sam had been prescribed *'just in case'* antibiotics, she had not been given instructions about when to use them. Mrs Morrish said that at the time of Sam's consultation with the First GP, she felt that Sam had a *'nasty cold but was within the range of what I expect from his illness'*. The First GP said that on 21 December Sam *'didn't seem that ill'* but he had prescribed antibiotics anyway to save the family *'navigating the out-of-hours system'* during the Christmas period.
58. Mrs Morrish said that whilst she waited to be seen by the Second GP on 22 December, she was very worried because Sam had a hacking cough. She said that the Second GP appeared to be running late but no one at the Surgery told her what was going on. Mrs Morrish said she was exhausted and felt isolated and her anxiety levels were rising. Mr Morrish said that he felt that the whole experience of interacting with the Surgery was impersonal: there was no information about how long you might have to wait to see a doctor, and no apology, just an *'open ended wait'*.⁵⁹
59. Mr Morrish explained at the meeting that the paediatric consultant had told them that Sam had a streptococcal A infection and that this would have been in his system about 48 hours before he died. He asked the Surgery whether earlier antibiotics

would have helped. The Second GP (who saw Sam on 22 December) said that Sam's symptoms did not suggest that he had a bacterial infection.

60. Mrs Morrish said that she felt she should have *'tried to explain [Sam's condition to the Second GP] better'* and been *'more pushy'* and told doctors that Sam had been diagnosed with pneumonia a year ago despite his chest being clear. She recalled telling the Second GP that Sam had been drinking and had been wearing his nappy all day. She said that the Second GP should have checked Sam's nappy, and if it was dry, admitted Sam to hospital. The Second GP said that Mrs Morrish *'got [her] concerns across very clearly over the phone ... you communicated [Sam's condition] very effectively and we took it seriously'*.
61. Mr and Mrs Morrish asked about when the prescribed antibiotics should have been given to Sam. Mrs Morrish said *'you said three things – breathing, dehydration or stops communicating'*. Mrs Morrish said that Sam only stopped communicating when he lost consciousness in hospital and died. The lead GP at the Surgery said that although Sam was clearly developing a serious illness, his symptoms at the time did not indicate this. Mrs Morrish said that regardless of her son's symptoms, she knew her child best and the GPs should have listened to and understood her concerns. She added that if Sam had been seen by the same GP both days, they would have noted his deterioration.
62. At the meeting Mrs Morrish said that following Sam's death, the only call the family received from the Surgery was about medication for the family. She said

that she felt the Surgery was indifferent to what had happened. The First GP apologised and explained that he had the impression that the family did not want to hear from the Surgery because of their anger, and that staff were trying to be sensitive. The Second GP said he felt he was the *'last person [the family] wanted to speak to'*. Mrs Morrish acknowledged that she would have found it hard to speak to the Second GP, but a letter, card or a call from someone at the Surgery would have been good. The Surgery said that it was aware the family had been speaking to the paediatric consultant.

63. Mr Morrish said that it was 26 days before the Surgery first contacted them about what had happened (the allocated GP's visit to their home) and they had experienced grief, anxiety and panic attacks during this time. They had not received any information about counselling and knew nothing about the services available to them. He said that this left a lot of scope for thinking that the Surgery was *'hiding things'*. There was no thought given to how Sam's brother might be coping, and they were concerned how the events might affect his development. During the meeting, Mrs Morrish acknowledged that she and her husband *'have had advice on how to help [Sam's brother]'*.
64. The First GP said that the Surgery must help the family as much as it could. The Second GP acknowledged the Surgery's *'clumsiness'* in dealing with the period following Sam's death. He said that there had been a lot of communication in the Surgery about the events but it had *'failed*

[the family] *in how we communicated that'*. The First GP said that he did not know what the Trust was doing about speaking to the family, adding that the GPs were not *'experts with the next steps in dealing with grief'* but he could put the family in contact with the right people. Mr Morrish accepts that the Surgery offered to signpost him to various bereavement services but said they did not go on to do so.

65. The Surgery said that the PCT was conducting an inquiry, which would collate information about what had happened. It said the PCT was *'currently pulling together information'*. It also highlighted a number of learning points from its own review of the care provided for Sam. The Surgery said that amongst other things, it would: give clearer instructions about when to give *'just in case'* antibiotics; improve the visibility of certain information in patient records;⁶⁰ check unwell children's nappies and improve continuity of care (which GPs patients see). The Surgery accepted that it should have made personal contact with the family, rather than through the grandparents, and should have provided better bereavement support. It said it would provide a *'safety netting card'* for patients and carers in the future. The lead GP said that the doctors were *'really sorry. We would value it if you could continue to give us feedback ... when we get it wrong, we would like to do something about it'*.
66. Following the meeting, the Surgery installed a new telephone triage system that included training reception staff in how to direct patients through the

⁵⁹ The Surgery told us that while Mrs Morrish was waiting, a member of the reception staff saw how upset she was and offered her and Sam a drink.

⁶⁰ The Surgery explained that it would introduce a new computer system in May 2012 that would enable significant diagnoses and important medical information to be seen more easily. Those patients deemed to be at increased risk of complications from viral infections should be easily identifiable, thereby assisting GPs' decisions about their management.

telephone triage system, and making more staff available to take calls during the busy morning period. The new telephone system includes an option for patients to be passed through to the Surgery's 'emergency telephone', which is kept free from 'routine calls'. The First GP told us that the Surgery had always had such a facility, but the lead GP acknowledged that this has since been updated. The Surgery's patient participation group is monitoring its telephone triage process.⁶¹

The PCT's role following Sam's death

67. The PCT emailed the Surgery and the Trust on 18 January to confirm that it was to conduct a root cause analysis into the events surrounding Sam's care. It explained that it would like to arrange a meeting at which all organisations could get together to discuss an 'amalgamated chronology'. This email was not sent to NHS Direct or Devon Doctors Ltd. The PCT also told the Surgery that statements from the GPs involved in Sam's care would be used as part of this process. Later that week, the Surgery told the PCT that a chronology of events would be ready by 24 January. The PCT subsequently asked the Surgery to provide a timeline of events by 25 March, which the Surgery did. Mr Morrish told us that the only reason they knew the PCT was conducting a root cause analysis investigation was because the Surgery told them after they had asked what was happening about looking into the causes of Sam's death.
68. On 4 and 11 February, the PCT contacted the Surgery and the Trust about arranging the root cause analysis meeting. Following

a meeting with the PCT in early March, Devon Doctors Ltd were told of Sam's death. At the same meeting, the PCT became aware of Devon Doctors Ltd's involvement, and that of NHS Direct. On 9 March the PCT sent an email to all the NHS organisations involved in Sam's care asking them to confirm when they would be available to meet. This email was sent to NHS Direct, however, the person it was sent to was 'out of the office'.

69. The PCT and the Surgery discussed funding for locum cover to be paid for (by the PCT) in order that it could send relevant staff to the root cause analysis meeting and still provide GP cover for local residents.
70. Devon Doctors Ltd confirmed that they would send a representative, and said they had not been asked to provide any information as part of the root cause analysis process.
71. On 17 March the PCT emailed the organisations to confirm that the root cause analysis meeting would be held on 4 April. This email was sent to the same person at NHS Direct who was still 'out of the office'.
72. On 22 March Devon Doctors Ltd sent a chronology of their interactions with Sam and Mrs Morrish to the PCT. This included details of Sam's condition as described by NHS Direct on 22 December. The Surgery sent a copy of its chronology to the PCT a few days later.
73. Invitations to the root cause analysis meeting were sent on 30 March (the Wednesday before the meeting, which was scheduled for Monday 4 April). This email was again sent to the same person

at NHS Direct who was 'out of the office'. The PCT's email noted that the person was on leave until 31 March and reiterated an earlier request for a timeline 'as soon as possible'. There is no evidence the PCT tried to contact anyone else at NHS Direct. On returning to the office, the member of staff at NHS Direct contacted the PCT and told them that no one could attend the root cause analysis meeting at such short notice. However, she said that she would arrange for someone to listen to the voice recordings of the conversations Mrs Morrish had had with NHS Direct. NHS Direct called the PCT the following day to say that a preliminary review suggested that a 'higher disposition' (a more urgent referral) had been warranted in Sam's case and that the NHS Direct nurse adviser 'should have passed the call through to [Devon Doctors Ltd] as a "GP urgent" rather than "routine"'. NHS Direct sent its chronology to the PCT and said it had not had time to transcribe the calls. It said that the issues surrounding Sam's care would be investigated internally.

74. In mid March, Mr Morrish contacted the Surgery again because he wanted more information about the processes the First GP and Second GP had followed. He wanted to discuss why his son's nappy was not checked, and asked for more information about ongoing support for the family. On 1 April he emailed the Surgery and the PCT with a narrative of events his wife had prepared (Annex B). In the narrative, Mrs Morrish had indicated that the treatment and contact Sam had with the NHS was subject to delays from every agency he met. Mr Morrish noted that no one had ever asked for this information. He questioned how the NHS could see the whole picture, how lessons could be learnt, and how systems would improve.

Further action by the paediatric consultant

75. Following a meeting between the family and the paediatric consultant (on 30 March), the paediatric consultant wrote to the Surgery on 1 April to explain that the family had many questions about 'the system', and he would bring these to the root cause analysis meeting scheduled for 4 April. He told the Surgery that he had also spoken to the family about seeing a psychologist. Mr Morrish has told us that the paediatric consultant did not 'offer' to refer the family to a psychologist, the referral was 'dragged out of the Trust' after Mr Morrish became agitated during the meeting. He said that he felt the paediatric consultant did not think there was anything wrong (either physically or mentally) with the family.

The root cause analysis meeting

76. On 1 April the PCT emailed representatives at the Surgery, NHS Direct, Devon Doctors Ltd and the Trust with the agenda for the root cause analysis meeting, and a copy of the narrative of events Mrs Morrish had prepared for the Surgery. The PCT also emailed NHS Direct requesting a transcript of the call Mrs Morrish made to its service. The purpose of the root cause analysis meeting on 4 April according to the PCT was to review Sam's care to identify 'contributory factors' and 'cross agency factors', to learn, and to make recommendations to improve services. The agenda for the meeting set out various issues Mr and Mrs Morrish had raised, including appointment times at the Surgery and follow-up calls by the various organisations. The agenda included reference to 'some other aspects relating to the period after [Sam arrived at the Trust]' (the care Sam received at

⁶¹ Patient participation groups are a way for patients and GP surgeries to work together to improve services and to promote health and improved quality of care.

hospital). The organisations agreed that the root cause analysis investigation would consider the events leading up to Sam's transfer to hospital, and that the 'Trust would inform the meeting with findings and recommendations from their in-house [root cause analysis investigation]'. Devon Doctors Ltd told us that during this meeting, they told the PCT that they had voice recordings of Mrs Morrish's calls to their service.

77. After the root cause analysis meeting, Mr Morrish contacted the PCT to find out who had been present. The PCT told Mr Morrish that representatives from the Surgery, Devon Doctors Ltd, the Trust and the PCT had attended the meeting. They said the purpose of the meeting was to review the events leading to Sam's admission to A&E, identify gaps, good practice, or factors that led to his condition becoming critical. They said the root cause analysis report would be shared with the family when it was ready.
78. On 11 April the PCT emailed NHS Direct explaining that it had Mr and Mrs Morrish's consent to obtain the recording of the call Mrs Morrish made to NHS Direct.

What NHS Direct did

79. Following the root cause analysis meeting, there were internal discussions at NHS Direct about reviewing Sam's care. On 12 April NHS Direct began a 'local management review'.
80. NHS Direct held an 'incident briefing' on 14 April to discuss Sam's care. An initial investigation into the voice recordings found no issues with the systems used by staff to make clinical decisions. NHS Direct found that the NHS Direct nurse adviser should have made an urgent (rather than a routine) referral to an out-of-hours GP, and

a full investigation would 'aim to identify what led the nurse adviser [NHS Direct] to reach the outcome she did'. At the briefing, it was recorded that:

'no complaint or subsequent contact has been received from the family but a letter of condolence will be sent ... we were alerted to the incident via a request from the local PCT to provide information as part of a multi-agency [root cause analysis].'

81. On 18 April NHS Direct sent a letter of condolence to Mr and Mrs Morrish. It also told them it was conducting an internal investigation, and they could contact the chief executive if they needed more information. NHS Direct explained that:

'we will be happy to share any findings from the review with you. We will also be sharing our findings with the multi-agency group that was convened to review all the contact you had with the different agencies.'
82. Mr Morrish spoke to NHS Direct on 9 May. He said he was surprised that it had taken so long for NHS Direct to be told about his son's death, and that the investigations to date were disjointed and 'lacking in cohesion'. Mr Morrish asked for copies of the NHS Direct voice recordings to be sent to him, as well as:
 - a copy of NHS Direct's complaint policy;
 - a copy of NHS Direct's adverse incident policy;
 - confirmation of whether NHS Direct was invited to the previous meeting held on 4 April (the root cause analysis meeting), when it was invited to this meeting, and why no one from NHS Direct had attended; and

- a copy of the information sent to Devon Doctors Ltd by NHS Direct following Mrs Morrish's call to the service on 22 December 2010.

83. A couple of days later, the PCT emailed all the organisations involved in Sam's care. It said that a joint report containing information about the Surgery, Devon Doctors Ltd and the Trust should be presented to Mr and Mrs Morrish at the same time as the report being prepared by NHS Direct. The PCT said that the NHS Direct report had not been included in the combined report because 'it has gone through a different process'. It said that the reports should be sent to Mr and Mrs Morrish before any meeting with them so that they had the opportunity to ask related questions. The PCT added that it was likely that the final root cause analysis report would be ready toward the end of June, once NHS Direct had completed its investigation.
84. On 14 May NHS Direct emailed the PCT explaining that it was sending the family the voice recording of the call Mrs Morrish had made on 22 December. On 16 May the PCT asked NHS Direct again for copies of the voice recordings so that the PCT was aware of what had happened during the NHS Direct nurse adviser's assessment of Sam. NHS Direct did not send the PCT the voice recordings before Mr Morrish had obtained copies himself and sent them to the PCT. The PCT also asked Devon Doctors Ltd for a transcript of all telephone calls relating to Sam's care and they also asked NHS Direct to send copies of the algorithms the nurse adviser had used. The PCT explained that although the algorithms appeared to be contained in the information Devon Doctors Ltd had sent to it previously, it wanted to check it had the right ones.

85. On 18 May NHS Direct sent Mr Morrish the voice recordings, its complaint and adverse incident policies, and details of the information it had sent to Devon Doctors Ltd. NHS Direct explained that it was told of Sam's death on 9 March when an email from the PCT was sent to a member of staff who was out of the office. The PCT sent a follow-up email later in March, but the staff member was still away. NHS Direct said that by the time the staff member returned and read the messages, it was too late to send a representative to the root cause analysis meeting in April. However, it confirmed that it had told the PCT it would begin an internal investigation and would share the findings. It told Mr Morrish that it had 'made efforts to ensure that if no individual was able to attend [the meetings] that relevant information relating to your call to us was provided to these meetings'. Mr Morrish told us that he was left to listen to the voice recordings alone and unsupported.
86. Mr Morrish emailed NHS Direct on 24 May after listening to the voice recordings it had sent. He said he felt 'angry' with what he had heard. Mr Morrish said that the NHS Direct nurse adviser had not done her job properly, despite his wife mentioning a number of times during the call that Sam had vomited. He was also unhappy with the length of time it was taking to get information about what had happened to his son. Mr Morrish said he wanted to meet all the relevant organisations at the same time. NHS Direct told Mr Morrish that his concerns would be addressed as part of its internal investigation. On 24 May Mr Morrish emailed copies of NHS Direct's voice recordings to the PCT.
87. NHS Direct completed its internal investigation on 28 May. The initial investigation noted that Mr Morrish

had wanted certain concerns addressed, including why:

- the NHS Direct nurse adviser recorded that Sam did not have brown lumps in his vomit when his wife said he had;
- the NHS Direct nurse adviser recorded that Sam did not have rapid breathing when his wife had said he had;
- the NHS Direct nurse adviser had not recorded his wife's concern about Sam not urinating;
- the NHS Direct nurse adviser had not asked questions about whether Sam was sleepier than normal; and
- Sam had not been treated as an emergency and instructed to go to A&E.

88. NHS Direct also noted that Mr Morrish was unhappy with the time taken to complete its review.

89. As part of NHS Direct's internal investigation, Mrs Morrish's conversation with the health adviser was reviewed by a number of members of staff, including team managers and a clinician. Non-clinical reviews found that the health adviser's handling of Mrs Morrish's call was either excellent or good. The health adviser had asked most of the right questions, but the tone was very casual and could have led to Mrs Morrish experiencing anxiety. A clinical review found the NHS Direct nurse adviser's call to be *'unsatisfactory'*.

90. The clinical review highlighted that the information the NHS Direct nurse adviser recorded, about Sam's vomiting, rapid breathing and lack of urination, did not reflect what Mrs Morrish had told her; that the NHS Direct nurse adviser had relied too much on the information from the previous GP assessments (carried out at the

Surgery); Sam's past medical history was not explored; she failed to recognise that Sam was severely ill; and that Mrs Morrish's anxiety was not taken into account or appropriately managed. The review noted that the NHS Direct nurse adviser had failed to use *'critical thinking'* and did not ask enough questions about Sam's condition, or accurately record answers. NHS Direct concluded that, had the NHS Direct nurse adviser acted appropriately, *'a higher level of care may have been recorded'*. It also noted that since the incident, its systems had been updated to ensure that it was clear when patients had been reviewed previously by a healthcare professional. NHS Direct recommended that its advisers should ask about a patient's past medical history, ensure that all symptoms are checked to ascertain whether there have been any significant changes since a previous assessment, and the *'care giver's'* level of anxiety should be taken into account.

91. Mr Morrish contacted NHS Direct again toward the end of May because he was certain his wife had spoken to NHS Direct a second time. NHS Direct agreed to search for this second call but could find no record. It is now accepted that this was in fact the first call made by Mrs Morrish to Devon Doctors Ltd.

92. On 9 June NHS Direct wrote to Mr and Mrs Morrish with a summary of its internal investigation. It said that if the NHS Direct nurse adviser had accurately recorded Mrs Morrish's responses to the questions asked *'a higher disposition may have been reached'*. It said that the nurse adviser's assessment of Sam was not of the high standard it expected, and following analysis of her performance, she had been set a number of objectives to demonstrate that she could meet the expected standards.

93. Mr Morrish told NHS Direct the letter was too brief and underplayed the significance of what went wrong. Although he acknowledged that NHS Direct was not told of Sam's death for three months, he said he would have *'expected them to have co operated in a multi-agency investigation'*.

94. Mr Morrish emailed the chief executive of NHS Direct on 13 June. He said he was unhappy that no one from NHS Direct had attended the root cause analysis meeting in April. He asked which algorithms had been used to assess Sam, what the nurse's capabilities and performance had been, and for further details about NHS Direct's investigation and the information it had provided for the root cause analysis meeting.

95. Mr Morrish and NHS Direct's chief executive exchanged a number of emails relating to Mr Morrish's ongoing concerns about the NHS Direct nurse adviser's assessment of Sam, and NHS Direct's internal investigation. In their exchanges, the chief executive said that it was clear there were *'errors and omissions'* in the NHS Direct nurse adviser's assessment (which had been identified by the internal investigation). He said that *'had these errors and omissions not occurred the [NHS Direct] nurse adviser would have reached the conclusion, in all probability, that more urgent action was needed such as advising you to speak to a GP urgently or to take Sam to A&E'*. He added that if the NHS Direct nurse adviser had accurately recorded that Sam had brown lumps in his vomit, the algorithm would have recommended that Mr and Mrs Morrish take Sam to A&E. The chief executive offered a formal apology for this

failure, and said that appropriate action was being taken to address the failings and to put additional safeguards in place. He told Mr Morrish that NHS Direct had communicated its interim findings – that the NHS Direct nurse adviser should have referred Sam urgently to a GP (instead of making a routine referral) – to the PCT before the meeting in April. He also told Mr Morrish about NHS Direct's 'improving work performance' process (an internal process used to monitor and improve the performance of NHS Direct employees). The chief executive confirmed that whilst NHS Direct had only been informed of Sam's death in March, he did not think the organisation had responded promptly and apologised for this.

96. The chief executive said email addresses are now monitored when people are out of the office. He added that NHS Direct's interim findings had been discussed with the PCT, although the full findings were not available. He said even though they had little notice of the meetings, a representative should have attended the meetings.⁶²

What Devon Doctors Ltd did

97. On 16 May the PCT contacted Devon Doctors Ltd to say that Mr and Mrs Morrish had complained that they had had no contact from them. Mr Morrish told us he had explained to the PCT that he was *'disgusted'* that Devon Doctors Ltd had not made any contact with him or his family.

98. The chief executive of Devon Doctors Ltd subsequently wrote to Mr and Mrs Morrish on 17 May to offer condolences for the death of their son. The letter apologised

⁶² Mr Morrish told us that he had to *'fight to get [NHS Direct's] admission that there were any errors'*.

that he had not written to the family when he had first found out about Sam's death. He said that having reviewed the care provided for Sam, *'we are unsure that in the circumstances we could have responded any differently'*. He said that Devon Doctors Ltd would await the outcome of the root cause analysis investigation and would co operate fully with the investigation. After receiving this letter, Mr Morrish telephoned Devon Doctors Ltd. He asked for a copy of the recordings of Mrs Morrish's calls to its service. Devon Doctors Ltd hand delivered a copy of the voice recordings to Mr and Mrs Morrish on 23 May. On the same day, the PCT emailed Devon Doctors Ltd explaining that Mr Morrish had told it he had asked for their voice recordings, and could these also be sent to the PCT so that it was aware of what was said. The next day, Mr Morrish emailed copies of Devon Doctors Ltd's voice recordings to the PCT.

99. After listening to the voice recordings, Mr Morrish contacted Devon Doctors Ltd with concerns about the care given to Sam. He said that although the letter he had received from Devon Doctors Ltd indicated that there were no real issues with the standard of care provided, the voice recordings did not support this stance. He said that the voice recordings clearly highlighted failures including that:

- Devon Doctors Ltd only made one attempt to contact his family following the referral from NHS Direct;
- Devon Doctors Ltd's call to the family was from a withheld number, so he did not know who had called; and
- life-threatening decisions were made by

people who were not medically trained (including a driver).

100. Mr Morrish wanted to know why Devon Doctors Ltd told his wife she should take Sam to the Treatment Centre rather than A&E; why they had to wait for help when they arrived at the Treatment Centre; why these issues had not previously been identified; and why no one from Devon Doctors Ltd had contacted the family after Sam's death. Mr Morrish was also unhappy that it had taken Devon Doctors Ltd,⁶³ and the PCT, over five months to listen to the recordings. He said that they only did so after he had told the organisations of their existence.

101. Following a meeting between Mr and Mrs Morrish and Devon Doctors Ltd on 25 May, the chief executive wrote to the family to apologise for *'the failure in our service'*. At the meeting, the chief executive agreed that there were mistakes in the call made at 9.13pm (paragraph 49). He said that the call handler indicated that he knew Sam's condition was serious but did not sufficiently communicate this to the Treatment Centre. Nor did the call handler upgrade Sam's clinical status to urgent, despite knowing that Sam was bringing up *'black fluid'*. A further error was made when the call handler failed to make it clear to Mrs Morrish that the decision to send Sam to the Treatment Centre followed a discussion with someone who was not a clinician.

102. The chief executive said that when Sam arrived at the Treatment Centre, he should have been prioritised and seen urgently, and Mrs Morrish should not have had to seek assistance. He said that the records

indicated that Mrs Morrish waited for about seven minutes but he acknowledged that she thought the wait was more than double that. Mrs Morrish said that the wait was definitely longer and that this could be proven by records of calls Mr Morrish made whilst waiting for Sam to be seen by a doctor. The chief executive said that Devon Doctors Ltd had been in contact with their software providers and their system had been updated to make *'call backs'* more prominent to their staff. He added that children *'vomiting black or brown coffee like granules'* had been added to their list of emergencies and all non clinical staff would be retrained in how to handle call backs and situations deemed to be an emergency. The chief executive said that the failures could be put in the context of that evening's workload, which could in some way explain, *'but not excuse'*, what happened, and he apologised. Devon Doctors Ltd told us that they had been aware of the family's concerns, because Mrs Morrish's narrative of events (Annex B) had been discussed at the root cause analysis meeting. They assumed that the PCT had passed their responses to the family's concerns back to the family, and said that it only became apparent that this had not happened when Mr and Mrs Morrish told them that they still had unanswered questions. The Devon Doctors Ltd told us that they deeply regretted not making earlier contact with the family, and apologised for not doing so.

103. Mr Morrish has told us that he expected some level of contrition from Devon Doctors Ltd, an explanation of what went wrong and an apology. He said that this did not happen and all the family received was *'a lot of self justification about how their systems work ... how busy they were at the time'*. Mr Morrish said that Devon Doctors

Ltd were still under the impression that their failings in care did not delay Sam's arrival in hospital. Mr and Mrs Morrish said that after they received Devon Doctors Ltd's letter of 17 May, and after the meeting on 25 May, they were unable to believe that the organisation could think that Sam had received appropriate care. They could not understand how Devon Doctors Ltd could make improvements if they could not accept they had made any failures in care.

104. Mr Morrish told us that the meeting with Devon Doctors Ltd was a *'nightmare'* and the organisation spent the first 30 minutes telling the family how busy the doctors had been that night. Mr Morrish said that Devon Doctors Ltd's medical adviser tried to *'explain away our shock ... that there was "no real concern" about a young child that had vomited black liquid despite not having eaten'*. Mr Morrish said they were told there were a number of *'things besides blood that could cause [vomiting black liquid], including alcohol'*. Mr Morrish said that this was unbelievable and causes him and his wife anger to this day. He said that he later discovered that Devon Doctors Ltd thought the meeting had gone well and *'once again, there was a total disconnect'*.

The root cause analysis report

105. On 18 May the first version (a draft) of the root cause analysis report was sent to the Surgery, NHS Direct, Devon Doctors Ltd and the Trust for comment. The report noted *'care and service delivery problems'*, identified contributory factors, root causes and lessons learnt, and made recommendations. This was a draft report, which was not sent to Mr and Mrs Morrish. There was little detail about NHS Direct's involvement in Sam's care.

⁶³ Devon Doctors Ltd told us that they had reviewed the recordings earlier in 2011 (which was why they were able to tell the PCT, during the root cause analysis meeting, that the recordings existed), but accepted that they did not send the recordings to the family until this was requested in May.

106. At the beginning of June, the PCT emailed the NHS organisations to confirm that, following Mr Morrish's request, a meeting had been arranged for 28 June to discuss Mr and Mrs Morrish's outstanding concerns.

107. On 9 June the Trust emailed the PCT asking for amendments to be made to the root cause analysis report, including the reasons why nurses had not given Sam antibiotics in A&E. The PCT's draft root cause analysis report indicated that Sam was not given antibiotics '*most probably due to education and training*'. The Trust said that this was not the case, and that he was probably not given antibiotics:

'due to time constraints as Sam was only in A&E for 2.5 hours before being transferred to the [high dependency unit]. During that time he was reviewed by [various doctors]. All medical and nursing staff working in the clinical area are fully competent in the administration of antibiotics, however the adult nurses are less familiar with the administration of such drugs to children.'

108. The PCT agreed to omit the reference to education and training from a revised report. The root cause analysis report that was sent to Mr and Mrs Morrish on 14 June, and the final version of the report, stated that there was a delay in Sam receiving antibiotics because of '*the lack of [a] paediatric nurse overnight in A&E, combined with the reluctance of A&E staff to calculate doses for children and administer them*'. The Trust subsequently told us that this statement is incorrect, and that Sam was not given the antibiotics sooner because transferring him to the high dependency unit took priority (the paediatric consultant told us staff got their priorities wrong and that staff had not been 'reluctant' to give Sam antibiotics).

109. On 12 June Mr Morrish emailed the PCT with questions about the meeting scheduled for 28 June. In addition to who would be present, Mr Morrish asked whether the root cause analysis process itself would be discussed, and whether NHS Direct would go into more detail about its involvement. The PCT explained that representatives from the relevant NHS organisations would be present, and clarified that the meeting would be about '*the [root cause analysis] of what happened to Sam*' and why there were so many delays in progressing the root cause analysis itself. The PCT said that information not available to the root cause analysis meeting in April would be discussed, along with any actions that had been or would be taken, to form an '*overarching action plan*' that it would monitor. The PCT told Mr Morrish that one of its representatives would chair the meeting.

110. A couple of days later, Mr Morrish emailed the PCT asking for a copy of the Trust's internal investigation report into his son's death, and copies of the various organisations' complaints policies. The PCT sent the policies to Mr Morrish and a list of who would be attending the meeting on 28 June. The PCT told us that it could not tell Mr Morrish whether the paediatric consultant would attend the meeting because the Trust had not confirmed whether he would be there.

111. As referenced above, Mr and Mrs Morrish first received a copy of the root cause analysis report on 14 June. This differed from the initial draft report. In particular, version five stated that the evidence reviewed now included '*voice recordings from NHS Direct and Devon Doctors Ltd*'. The report recommended that in the future, in organisations where voice recordings are routinely made, they

should be reviewed at the root cause analysis meeting. Despite the root cause analysis report stating that the voice recordings from NHS Direct had been reviewed, information about the calls was not included in the report because NHS Direct had not completed its investigation. Instead, the PCT stated that the voice recordings were one of the '*areas [that required] clarification [with NHS Direct]*'. The root cause analysis report contained additional information about Devon Doctors Ltd's voice recordings. It identified that a telephone call Mrs Morrish made to the organisation at 8.52pm was not properly documented on their computer system, and that Mr and Mrs Morrish were not told that the decision to send Sam to the Treatment Centre was made after discussions between staff who were not medically trained. Version five of the root cause analysis report included additional recommendations. These included that staff at the Surgery should: check the nappies of children who have symptoms of fever; have a greater awareness of streptococcal A infections; improve its computer record keeping in order that patients' past medical histories can be more easily identified; and give patients the opportunity to see the same GP. The report also commented that the Surgery should have had direct contact with Mr and Mrs Morrish sooner. Version five of the root cause analysis report recognised that where there are complex '*multi agency*' investigations in the future, the chair of the root cause analysis process should take a lead in explaining the process to the family and co-ordinating responses. The root cause analysis report stated that '*there is a lack of availability of paediatric nurses working in A&E to give complex medications, such as antibiotics, to children*'. There were no recommendations to address the failure

to give Sam antibiotics. Mr Morrish told us that the root cause analysis report '*did everything linguistically possible to avoid apportioning blame to anyone for anything*'. He said that it '*missed the point*'.

112. Mr Morrish contacted Devon Doctors Ltd on 15 June after he had received the root cause analysis report. He said that he felt the report had relied on his wife's narrative of events (provided before the root cause analysis meeting in April) as a finite list of questions to be answered. He said that each organisation should have scrutinised its own involvement, spoken to the family, and given information about its findings to the root cause analysis process. The chief executive of Devon Doctors Ltd responded the same day explaining that while he accepted that they '*had a role within the [root cause analysis] we did not think that our role was central to the [root cause analysis]*'. Any inadequacy in their investigation was because they trusted the root cause analysis process. The chief executive said that '*there were criticisms that could rightly be made of aspects of our service ... however I remain of the view that those criticisms did not affect the sad outcome for your son*'.

113. Mr Morrish responded to the chief executive's email, and his previous comment that he was unsure that in the circumstances Devon Doctors Ltd could have responded any differently. Mr Morrish felt that the root cause analysis process was so flawed that Devon Doctors Ltd should not have waited to be told what went wrong and how to put it right: any issues should have been identified during their own investigation. He said that both the root cause analysis and Devon Doctors Ltd had failed to ask the basic question of why they were told to take their son to the Treatment Centre rather than A&E.

Mr Morrish said that Devon Doctors Ltd investigation had failed to identify the lack of verbal assessment of Sam's condition by the call handler; the call handler's failure to tell his wife that they had not spoken to a clinician about Sam's condition; the failure to pass on critical information to relevant staff at the Treatment Centre; or the excessive waiting time at the Treatment Centre. He said that he had no confidence that Devon Doctors Ltd had understood the issues or corrected them.

114. Over the next couple of days, Mr Morrish sent a list of questions to Devon Doctors Ltd and the Trust so that these organisations were briefed on his outstanding concerns before the meeting.

115. In correspondence with the chief executive of NHS Direct, Mr Morrish said that the report did not accurately portray what had happened. The chief executive confirmed that the NHS Direct nurse adviser made an inappropriate referral to Devon Doctors Ltd, and that the NHS Direct nurse adviser failed to accurately assess Sam. He said that a more urgent referral 'should' have been made. He accepted that it was wrong for previous reports to have suggested that it 'may' have been appropriate to refer Sam urgently. The chief executive told Mr Morrish that whilst the algorithm used by the NHS Direct nurse adviser included a question about how sleepy a child was, staff did not have to repeat these questions verbatim. However, he said that in Sam's case, this issue should have been probed further. While a positive response to this question would not, on its own, have been 'sufficiently alarming' to prompt an urgent referral, he said it should still have been explored further. The chief executive confirmed that if the NHS Direct nurse adviser had recorded 'yes' to the questions about whether Sam

had vomited coffee ground-like material, the advice would have been to take him to A&E. Mr Morrish has told us that he had to repeatedly ask the chief executive to attend the meeting planned for 28 June, and it took a great deal of persistence from him before the chief executive agreed to do so.

116. Mr Morrish asked the PCT to obtain a 'truly' independent chair for the meeting who would answer all his questions. Mr Morrish explained that the root cause analysis process had failed to address pivotal questions, missed relevant information and had established a false picture of what had happened. He said that this was a 'disgrace', that the investigations conducted by the individual organisations were 'clearly inept', and the PCT should have spotted this. He said that the organisations involved had still not established why a GP failed to check Sam's nappy; whether the out-of-hours doctors tried to call them back; why they were told to take Sam to the Treatment Centre; why they were told to wait in a queue; and why they had to ask for help from a passing nurse. He said that the answers to these questions were in the voice recordings, but no one had listened to them until months after Sam's death. Mr Morrish was unhappy that no one had spoken to the family to find out their view of what happened, and was unhappy that the process had taken so long. He said that the organisations should gather all the evidence relating to his son's death, and what had happened to the process afterwards. Only then would 'the NHS' be able to see the differences between the picture portrayed by the root cause analysis, and what actually happened.

117. Mr Morrish spoke to the PCT on 15 June, again questioning the appropriateness of a member of its staff chairing the forthcoming root cause analysis meeting. The PCT asked him to write down his thoughts about who might chair the meeting instead. The following day, Mr Morrish emailed the PCT explaining that:

'the [PCT's root cause analysis] process itself is now the focus of so many questions, not just from me, but also from some of the organisations that have fed into it, that on top of everything else, it (the root cause analysis process) also needs to be critically analysed and held to account (if it has indeed been mishandled), which I suggest at least partially undermines its ability to do its job.'

'...

'Whilst I am clear about certain things – I am unclear about how to proceed from here – but I am not content to either leave things as they are (in a mess), or to simply cross my fingers and hope that [the PCT] gets it right next time, either for us – or for anyone else. Left to their own devices – I don't believe they will.'

118. Mr Morrish told us that the PCT was adamant that it was best placed to chair the root cause analysis meeting. He said that 'it took a lot of debate/argument from me to explain the inappropriateness behind the decision [for the PCT to chair the meeting] given their abysmal performance up until that time'.

119. The PCT acknowledged Mr Morrish's email, and following his concerns about who

would chair the meeting, confirmed that the meeting would be chaired by the chief executive from another trust (the Chair). The PCT told Mr Morrish that the Chair would provide the objectivity the family required, and that a wider independent investigation should achieve the outcomes he sought. Mr Morrish has questioned how 'independent' the Chair was. He says that because leaders from both the PCT and the other trusts sit on each other's committees, he does not feel that the Chair was as independent as he appeared. He said 'the decision [to change the chair of the meeting] was not voluntary. It was definitely made under pressure from me' and he is 'absolutely convinced that whilst the PCT wanted to give the impression of an independent investigation - it was not in fact as independent as it appeared to be to us at the time'. One of the successor organisations to the PCT (Northern, Eastern and Western Clinical Commissioning Group) told us that when the PCT suggested to Mr Morrish that it would chair the root cause analysis meeting, 'Mr Morrish was understandably very concerned about this and made clear his view that someone independent should chair the meeting'. It added that it:

'agreed to find an independent chair and having secured the chief executive of another organisation he then met Mr Morrish.⁶⁴ Mr Morrish then agreed to go ahead with the meeting. If Mr Morrish had not agreed to this person chairing, the PCT would have continued to find an appropriate and suitable independent chair.'

120. On 20 June Mr Morrish emailed the PCT to raise questions about the validity of the root cause analysis report. In particular, he

⁶⁴ It should be noted that the meeting the PCT is referring to took place immediately before the meeting was due to start on 28 June.

said that the report had little information about the involvement of NHS Direct, and had no information relating to the voice recordings. Later that day, Mr Morrish emailed the same list of questions to the chief executive of NHS Direct.

121. On 23 June the PCT confirmed that the paediatric consultant who treated Sam in hospital would not be attending the meeting. The next day, the Chair wrote to all the organisations due to attend the meeting on 28 June. He said that there were a number of unanswered questions and the meeting was an opportunity to review what had happened. The Chair said he would look at how the root cause analysis process could be improved because Mr and Mrs Morrish did not believe that they had been given all the facts, or that lessons had been learnt.
122. Before the meeting, NHS Direct emailed the PCT with updates to the root cause analysis report. On 24 June the PCT sent the final version of the first root cause analysis investigation report to Mr and Mrs Morrish and the organisations involved in Sam's care (Annex E). This report contained more details of NHS Direct's involvement, including an analysis of the voice recordings, and details relating to the NHS organisations' internal investigations and learning points. The report also stated that *'there had been no intentional delays and no unexplained moments that would have constituted a delay'*.
123. Mr Morrish emailed the chief executive of NHS Direct with further concerns about the root cause analysis report, in particular that there was little detail about NHS Direct's involvement. The chief executive explained to Mr Morrish that the first root cause analysis report contained little information about his organisation's involvement because the

other organisations had had over three months to review their involvement. The chief executive said that once NHS Direct had completed its review, the information was emailed to the PCT and that he was disappointed the PCT only included its report as an addendum.

124. Before the meeting, Devon Doctors Ltd completed their internal investigation into the care provided for Sam. This found that a doctor had tried to call Mr and Mrs Morrish when information about Sam was passed to them by NHS Direct. Devon Doctors Ltd identified a number of issues relating to the call handler. They found that the call handler had not logged information properly on to the system (including escalating Sam's condition from routine to urgent) and the advice given to Mrs Morrish to attend the Treatment Centre was not based on clinical advice. Whilst this report was primarily for the board of directors at Devon Doctors Ltd to review, the report stated that *'a root cause analysis is being undertaken by the PCT due to the multi-disciplinary nature of the patient pathway and this report will feed into this process'*. The investigation report highlighted various failings in their service and concluded that:

'the decision [to send Sam] to [Newton Abbot Treatment Centre] did give the quickest access to a GP. It did not necessarily delay [Sam] being seen in A&E or contribute to [Sam's] sad death. This does not mean that there are no failings or learning for Devon Doctors Ltd namely:

- *Vomiting black liquid/coffee grounds being shown as an urgent rather than emergency priority;*
- *Human error by the call operators in the documentation of their actions;*

- *Lack of clarity in communication between the call operator and the receptionist to the family;*
- *Failure of the Governance team to locate the first contact to the control centre [by Mrs Morrish];*
- *Failure to make direct contact with the family, assuming that feedback and liaison was being dealt with via the [root cause analysis] process.'*

125. Devon Doctors Ltd set out a number of actions that had been taken, and that should be taken, to improve its service. These included reviewing the escalation process for children vomiting black liquid, and arranging training for non clinical staff. As part of its ongoing processes, Devon Doctors Ltd agreed to review its improvement plan until all outstanding actions had been completed. Devon Doctors Ltd noted that it was not involved in the root cause analysis process until March, and had been unaware of Mr and Mrs Morrish's outstanding concerns.
126. On 24 June the Trust obtained a statement from the paediatric registrar who saw Sam during his admission to hospital. He said that Sam had looked very unwell and needed oxygen. After checking his observations, he gave Sam fluids, which he seemed to respond to. He was concerned that Sam might have severe pneumonia or infection-related intra-abdominal bleeding and he telephoned the paediatric consultant to discuss Sam's symptoms. He said that the paediatric consultant told him that Sam should have a chest X-ray, and should be reviewed by a surgeon and intensive treatment unit specialist. The paediatric consultant told him that he would return to hospital. The paediatric

registrar said that he prescribed antibiotics and ranitidine, and a chest X ray showed Sam's right lung had filled with fluid, which indicated he had pneumonia. He said that the surgical team assessed Sam and thought it was unlikely that he had a problem with his abdomen. He discussed Sam's care with the paediatric consultant (who had arrived back at the hospital) and arranged for Sam to be transferred to the high dependency unit. He said he completed the handover process at about 12.45am and he saw Sam again at 1.45am in the high dependency unit, by which stage Sam was breathless, had a weak pulse and had not passed urine for three hours despite having been given fluids. Because of his high C-reactive protein levels, the paediatric registrar thought Sam might have been in septic shock. The paediatric registrar said that when he saw Sam again later that night, he was bleeding from his nose and mouth and he was restless and agitated. He said he was very concerned about Sam's condition and spoke to the paediatric intensive care unit at a different hospital. He was advised to stabilise Sam, but very soon afterwards, Sam had a cardiac arrest.⁶⁵ Doctors attempted to resuscitate him, but without success.

The meeting on 28 June

127. The meeting on 28 June was led by the Chair and was attended by representatives from the NHS organisations involved in Sam's care, and Mr and Mrs Morrish. The following information is taken from the minutes of the meeting. The Chair explained the purpose of everyone being there. He said that Mr and Mrs Morrish were distressed and grieving, and the root cause analysis report did not reflect what individual organisations had told

⁶⁵ The cessation of normal circulation of the blood due to failure of the heart to contract effectively.

them, nor did it reflect their experience or identify any contributory factors. Mr and Mrs Morrish wanted the organisations to recognise what went wrong, apologise, and take action to prevent recurrence of the failings.

128. The Chair recommended that the current root cause analysis process be stopped and that a new independent review should *'pull everything together into a new, more accurate review and report'*. He noted the failures Mr and Mrs Morrish had identified, including the GPs' failure to consider the dryness of Sam's nappy, the failure to correctly prioritise the NHS Direct call, the decision to send Sam to the Treatment Centre, and a delay in Sam receiving antibiotics. The Chair said that Mr and Mrs Morrish wanted to know whether the NHS organisations accepted that there were delays and errors, and that these had lessened their son's chance of surviving.
129. The Chair set out the 'terms of reference' of the new investigation, which were to:
- listen to the views and opinions of Sam's parents;
 - review the 'whole system', taking account of issues in the organisations;
 - review the organisations' reports prepared to date;
 - identify emergent themes;
 - apply clinical judgment to what happened;
 - identify root causes of what went wrong;
 - identify contributory factors;
 - identify learning (and good or bad practice); and
 - make recommendations to minimise the risk of failures happening again.

130. The PCT acknowledged that its root cause analysis investigation had been disjointed. The Chair agreed that the new report needed to highlight mistakes, provide an apology, and demonstrate what remedial actions had been taken. He said that to date, the root cause analysis had had *'no clear purpose'* and: *'we have missed the mark by some considerable way ... we must acknowledge the family's not unreasonable disappointment in the performance of the NHS'*.

131. The Chair explained that the family's main concern was the organisations' failure to recognise Sam's illness early enough. Any issues should be *'clearly articulated in the new report, clear in terms of learning'*.

132. At the meeting, Mr Morrish said that he hoped that the new investigation would be open, so that *'hopefully the service in the future won't bruise and damage people in the way it has damaged us'*. He added that it was *'outrageous'* that what was being discussed in the meeting was only just being talked about and that the investigation that followed his son's death should be *'reviewed as seriously as the incident itself'*. Mrs Morrish added that the NHS needed to look at Sam's care as a whole, and consider the implications of any mistakes. At the meeting, the Trust said that it was:

'not sure that we will get a definitive answer in terms of the implications. I'm not sure we will be able to confidently say "if this had occurred at this point then this would have happened". It's difficult to draw conclusions with confidence.'

133. Mrs Morrish said the family was not saying that Sam would have lived, but there was a delay and the NHS should apologise. Mr Morrish said that *'as far as I'm concerned you [the NHS] are one*

organisation'. Following the meeting, it was agreed that the new investigation, overseen by the Chair, and conducted by two independent investigators (a director of nursing and a consultant paediatrician, from another hospital trust), would be completed within four to six weeks – that is, by 31 August.

134. Mr Morrish told us that, along with the days running up to and including Sam's funeral, the meeting was one of the hardest days of his life, and very stressful. He said that the meeting itself was *'unbelievably and unbearably stressful'*.

What happened after the meeting

135. On 7 July Devon Doctors Ltd updated the conclusion of their investigation report. They sent Mr Morrish an updated report which included the following statement:

'vomiting black liquid was not given an emergency priority. If an ambulance had been called following the contact at 9.08pm the best case scenario was that Sam would have been seen by a paediatric team approximately 30 minutes earlier. The actual time of arrival could have been later still if the mother of Sam had not alerted the passing nurse of her concerns and if there had not been an ambulance passing [Newton Abbot] when the GP made the 999 call.'

'The mother of Sam was not told [by the call handler] that he had spoken to a member of support staff at [Newton Abbot] and not a clinician. If Sam's parents had known this they may have disregarded the call operator's advice and taken Sam direct to hospital. The A&E department would have been extremely busy that evening however if the parents had taken their child

to A&E direct, the best case scenario is that they would have been seen by the paediatric team approximately 30 minutes earlier.'

136. After reading the updated report from Devon Doctors Ltd, Mr Morrish questioned the accuracy of its chronology, and the finding that only 30 minutes was *'wasted'* before an ambulance was called for Sam. Mr Morrish told us that while Devon Doctors Ltd listed things they had done, they failed to mention that he and his wife had disputed parts of the report, and that questions remained unanswered. Mr Morrish's concerns were passed to the independent investigator.

137. On 11 July the PCT asked the Surgery for copies of Sam's medical records so it could send them to the independent investigators. The PCT also asked NHS Direct and Devon Doctors Ltd for copies of the voice recordings. The same day, Mr Morrish asked the PCT and the independent investigator when he was likely to see the new report. He said he was concerned that there might be delays and any findings would not be ready by the end of August. Mr Morrish also asked if a further meeting (with all the relevant organisations represented) could be arranged once the new report was ready, and if the independent report answered all his questions, the meeting could be cancelled. Mr Morrish told the PCT that by organising a meeting now, and having appointments agreed in the relevant peoples' diaries, it would *'avoid any additional waiting or uncertainty'*. Mr Morrish said that his request for a meeting was, in his view, deliberately ignored and that:

'no one wanted to be in that situation again. I wanted [a new meeting] to focus their minds ... to increase the pressure to get the second investigation report right. They should have agreed to this. They did not, and of course they went on and messed up the second report too.'

138. On 12 July 2011 NHS Direct conducted a review of its handling of its own investigation. It concluded that there was a delay of some 13 days in raising the incident internally and beginning the review (this should have taken place within 24 hours of NHS Direct being made aware of the incident). It attributed the delay primarily to the workload of staff and said that once team managers and the clinical adviser had been asked to review what occurred, it took six weeks for the review to happen. NHS Direct said that internal investigations should be completed within 28 days but in this case it took eight weeks.

139. The internal review highlighted a number of recommendations to improve the quality and timeliness of its investigations. These included:

- there should be accountability for raising the incident internally within 24 hours of being told about it;
- staff should be trained to understand the need for timely call reviews;
- managers should be trained to ensure that call reviews are of an acceptable standard;
- managers should be made aware of NHS Direct's policy for conducting investigations;
- there should be greater liaison with the PCT to ensure that NHS Direct is involved earlier in similar cases; and

- NHS Direct should attend all external meetings following a patient death.

140. In conclusion, NHS Direct said that it had a 'thorough process for reviewing incidents, however, due to a variety of issues the policy is not being adhered to which potentially creates clinical risk for the organisation'.

141. On 14 July Mr Morrish emailed the Surgery with a list of concerns. He felt that the original root cause analysis had simply collated information gathered from the various organisations and that the more complex medical issues had not been 'probed' enough. He felt that by the time Sam saw the Second GP his illness should have been detectable. He added that the Surgery should look again at the telephone assessment of Sam during the morning of 22 December, and the decision not to give Sam an earlier appointment. This email was copied to the independent investigators involved in the new investigation process, the Chair, and the PCT.

142. Mr Morrish emailed one of the independent investigators on 20 July to discuss meeting them. He said 'we were assured that we would be central to the second [root cause analysis investigation]. If we do not meet until the report is finished – in what sense would we have been put at the centre of the [root cause analysis investigation] into Sam's unexpected death?'. He asked the independent investigator whether 'you have now met, or will you be meeting with the various agencies/clinicians involved in Sam's care ... [the lead GP at the Surgery] is certainly hoping to hear from you soon'. In response, the independent investigator told Mr Morrish that:

'We can discuss the form of the review when we meet on [22 July] but

to reassure you, the review will be constructed of two main sections:

- *a review of Sam's clinical care across all the agencies involved*
- *a review of the process that was followed including the root cause analysis process*

'[The other independent investigator] is essentially providing me with the expert clinical view regarding Sam's clinical care. The way in which he will do this is through a thorough review of Sam's medical records and if necessary via consultation with the various clinicians involved in Sam's care. In addition he will look at the clinical evidence base or "best practice".'

143. The Surgery contacted the PCT the same day requesting an update on the independent investigation, and asked when its GPs would be interviewed. The PCT told the Surgery that it had spoken to the investigators and confirmed that they would not need to meet the Surgery because they had all the information required. Later that day, Mr Morrish wrote to the PCT, the independent investigators and the Chair. He was concerned that the new investigation would be a 'paper-based review of the information concerning Sam that has already come to light through the first [root cause analysis]'. He said that the problem with the root cause analysis stemmed from the 'back-office paper based nature of the process', and he wanted some assurances that relevant clinicians would be spoken to. He said he wanted the findings relating to Sam's care, and the subsequent NHS investigation process, to be separated.

144. On 21 July the PCT told Mr Morrish that it did not think the investigation would be a 'paper-based exercise' and that the

findings about the care given to Sam, and the subsequent investigation process, would be separate, but 'may sit in the same final report'. The PCT agreed to pass on his concerns (as well as the comments from the Surgery) about the GPs being interviewed.

145. On the same day, one of the independent investigators (the paediatrician) emailed Mr and Mrs Morrish to explain his role in the investigation. He explained that he would review all the correspondence, recordings, and medical records, and:

'if necessary will consult with the various clinicians involved in Sam's care ... it is then my intention to go through my findings with you face to face, hopefully on 30 August to allow you to ensure the report is factually correct and to answer any part of your questions regarding Sam's clinical care.'

146. The following day, one of the independent investigators (the director of nursing) met Mr and Mrs Morrish to discuss their concerns. During the meeting, the independent investigator explained to the family that there would be a review of the clinical care Sam received, and a review of the subsequent investigations into what happened. In an email to the Chair on 25 July, the independent investigator said:

'what is needed [from the independent investigation] is a critical and objective analysis of these reports [the previous investigations] reflecting the journey experienced by Sam and his parents. In addition, as should have happened in the first instance, the parents' narrative, perceptions and reality will play a central role ... [we] will meet the GPs.'

147. The lead GP, and the First GP and Second GP, were interviewed by the independent

investigators. The paediatric consultant was also spoken to by telephone. We asked one of the independent investigators (the consultant paediatrician) to explain why he interviewed the people he did. He told us that the terms of reference of the investigation included applying professional judgment to the care provided for Sam and the possible clinical consequences. He said that:

‘after reading the available clinical reports and listening to the audiotapes,⁶⁶ I felt it was necessary to speak to the [First and Second GP] and the [paediatric consultant at the Trust], to understand their actions further. These discussions helped me in forming a clinical opinion as part of the clinical root cause analysis.’

148. On 3 and 18 August the independent investigators spoke to a rapid response practitioner and a child death review service manager about bereavement support in the region. After these discussions, the independent investigators established that in Sam’s case, the paediatric consultant ‘assumed the role of lead professional in fulfilling a “duty of care” to the family’ following his death.

149. On 12 August the Trust submitted further information to the investigators conducting the new investigation. The Trust explained the process that usually follows the death of a child, and the bereavement support offered to families. It said that families should be given contact details of the bereavement office, and offered support from a chaplain or religious services. The family should also

be given the opportunity to talk to the consultant involved in their child’s care within six weeks of their child’s death. The Trust said that its records showed that these steps took place in Mr and Mrs Morrish’s case. It said that following the last meeting between the paediatric consultant and the family (on 30 March), Mr and Mrs Morrish were referred to a psychologist. The Trust explained that it was unclear what information had been passed to the Surgery about bereavement support, although it had sent a copy of the psychology referral to the GPs. The Trust confirmed that it had engaged in the root cause analysis process and had shared information with relevant organisations. The Trust also sent a summary of key learning points and updates to its process, which included:

- paediatric early warning scores to be recorded in order to improve the recognition of serious illness and the reporting to senior clinicians. Although paediatric early warning scores were being piloted when Sam was in hospital, their use had now been formally rolled out throughout the Trust;
- developing a paediatric sepsis bundle,⁶⁷ which should mean that patients are treated as soon as sepsis is suspected;
- staff had undergone paediatric simulation training (from February 2011) to help teams effectively manage children with serious illness or injury;
- a teaching session dealing with the advanced management of septic shock had been organised; and

- acknowledging that the multiagency investigation was not as well run as expected and the Trust would produce written guidelines for the child health directorate to improve co-ordinating contact with families, internal departments and external agencies.

150. The independent investigators’ report was produced in light of the relevant clinical records, various investigation reports and meetings with Mr and Mrs Morrish, which included discussions about bereavement support. Mr Morrish told us that although Sam’s clinical records were reviewed, only one of the independent investigators met them and there was little or no discussion, before the meeting of 30 August, about the clinical care Sam received.

151. On 30 August Mr and Mrs Morrish met the independent investigators to discuss their draft investigation report before it was sent to the Chair the following day. They were given a copy at the meeting. This was the first time Mr and Mrs Morrish had seen the report. The meeting lasted for about eight hours. A copy of the report is at Annex F. Mr Morrish told us that the report failed to properly examine the involvement of Devon Doctors Ltd because it only referred to clinical issues, and not the level of service Devon Doctors Ltd provided (including staffing levels and response to telephone calls). Mr and Mrs Morrish told us that it appeared the investigation had an immovable deadline of 31 August and the report was going to be signed off then regardless of whether it was correct. They felt like they were being asked to ‘rubber stamp’ a report without having sufficient time to read it, and said the report should have been shared with them before the meeting. Mrs Morrish told us that she had to temporarily leave the meeting in tears when she heard how Sam died, but she

then returned. Mr and Mrs Morrish told us that the terms of reference set out that the investigation would identify the root causes of what went wrong. However, when they were presented with the report, there were no root causes for what had happened.

152. Mr and Mrs Morrish said that the investigation report used a lot of medical terms, which made it very difficult to understand. One of the independent investigators (the consultant paediatrician) told us that during the meeting, ‘we discussed in great detail the care Sam received. We went through the clinical report word-by-word, allowing Mr and Mrs Morrish to comment and ask questions which they did throughout’.

153. The following day, Mr Morrish emailed the independent investigators as he had more questions he wanted answered before the report was signed off. He said that he was given a copy of the draft report too late, and it was too much to ask him to review it in ‘one sitting’, especially as it concerned the death of his son. Mr Morrish added that ‘just to reiterate ... we are very grateful for the work both [the independent investigators] have done. Despite what I have written above – your work has moved everything forward in leaps and bounds for us. Thank you both’. The independent investigation report was signed off by the Chair that day.

154. In respect of the clinical issues, the independent report identified that there needed to be greater awareness of the risk of invasive group A streptococcal infection during a flu epidemic; the GPs at the Surgery should have paid closer attention to Sam’s heart rate and urine output; that the reasoning behind sending Sam to the Treatment Centre was based on geographical convenience alone and not

⁶⁶ The recordings of conversations Mrs Morrish had with the NHS Direct nurse adviser and the call handlers at Devon Doctors Ltd.

⁶⁷ This is a set of steps that should be taken within three to six hours of a patient being suspected of having sepsis (www.survivingsepsis.org/Bundles/Documents/SSC_Bundle.pdf).

on clinical requirements;⁶⁸ and that Sam should have received treatment sooner when he arrived at hospital to ‘*maximise his chances of survival*’. The report also identified that whilst some information about bereavement services was given to the family, there was a lack of clarity between the Surgery and the Trust about responsibility for managing this process. It concluded that, as a consequence, the family were left to pursue counselling themselves. The independent report said that the Surgery should give Mr and Mrs Morrish clarification about whether it had a ‘*fast track*’ telephone triage system for identifying sick children, or whether calls are simply dealt with sequentially. The report also identified that the NHS Direct algorithm used to assess Sam has been changed and ‘if a child is identified as vomiting black/brown “*coffee granules*” this is considered an emergency i.e. indicating that an ambulance needs to be called immediately’. The report stated that the algorithm ‘*is a poor screening tool for signs of early [sepsis], but ... the consultation did reveal increased respiratory rate, warm peripheries and reduced urine output suggestive of septic shock*’.

155. The independent investigators produced a summary of their findings, and concluded that:

‘the root cause analysis was viewed [by the NHS organisations] as an end in itself, rather than a methodology forming part of an investigation ... Therefore, the report represents a collation of individual organisations’ [root cause analysis] processes with limited expert clinical opinion spanning the total care pathway.’

156. The independent investigators also found that the root cause analysis investigation failed ‘*to actively engage with the family*’ and there was evidence that Mr Morrish had had to pursue the NHS organisations to establish what was happening to their investigations. In addition, there was a delay in identifying all the agencies involved in Sam’s care, and a possible lack of urgency in completing the investigation.

157. In response to Mr Morrish’s email (paragraph 153, this Annex), one of the independent investigators apologised to Mr Morrish if he felt that the meeting of 30 August:

‘was an 11th hour event prior to the submission of the report. We set up a meeting some weeks ago and I recall us having a phone conversation where you informed me that it was [Mrs Morrish’s] birthday on the 30th [August] and I asked you if you wanted to continue. You were keen to keep this date.’

She confirmed that the report satisfied the terms of reference, and that the investigation had been to review:

‘the evidence presented by all parties, apply critical objective opinion based on national and local evidence and draw conclusions in terms of findings. Recommendations are then presented in a bid to improve and minimise the risk of shortcomings recurring ... We talked yesterday about how any remaining issues you have would be dealt with and I suggested that you may need to raise specific organisational issues with those respective organisations.’

158. In response, Mr Morrish told the investigator:

‘You do not need to apologise ... I fully accept that you have been 100% up front about what was planned – and I know I agreed to it all. There is no sense in which I am suggesting that anything that happened yesterday was not agreed to by me ... I think we were both surprised by the sheer amount of information – nobody’s fault – just the way it is. I guess it is just that we had not anticipated so much. I had asked [someone earlier], if it was wise to review the report so close to the deadline. I accept there may well have been good reasons for doing so. My emails today were simply to point out that with so much information – it was a lot to deal with. With the benefit of hindsight – it was too much – but I am not blaming anyone ... I guess my concern is over the areas that we did not discuss in detail ... We really do appreciate the work you [the independent investigators] have both done.’

159. Mr Morrish met one of the independent investigators, and the Chair, on 8 September. It was agreed that he could raise his further concerns about the independent investigation and they could be included in the report. The following day, Mr Morrish emailed the Chair, and both independent investigators, explaining that:

‘I know we may not sound/appear grateful at times, as we struggle through the mire of everything that happened to Sam. But please accept our sincere thanks and appreciation for the sanity and reasonableness that you have brought to the NHS

investigations since June 28. The contrast with everything that went before it is profound. I know I still have questions ... but I want you all to know that collectively you have helped us to take a huge step forward. We no longer feel we are engaged in a battle.’

160. Mr Morrish emailed one of the independent investigators on 12 September because he wanted to see various documents referenced in the investigation report. She passed Mr Morrish’s request to the Chair on 14 September and emailed Mr Morrish saying:

‘I cannot speak on behalf of [the Chair] but I understand that the report we have now shared with you, for the purposes of learning and improvement would become the definitive document and would, essentially replace that which had gone before.’

161. Later, Mr and Mrs Morrish sent statements to the Chair to be included in the independent investigation report. Amongst other things, Mr and Mrs Morrish’s statements included their concerns about a lack of investigation into whether Devon Doctors Ltd had sufficient staff to provide an effective service on the night they saw Sam, the lack of an apology from the Trust for the delay in giving Sam antibiotics, and the ‘deeply rooted failure of [the PCT] to hold a multi-agency investigation’. Mr Morrish also had concerns about how the organisations could ensure that they improved their service, and what ‘meaningful difference’ more guidelines would make.

162. A follow-up meeting involving NHS Direct, Devon Doctors Ltd, the Trust, the PCT and the Chair was held on 30 September 2011. Neither Mr and Mrs Morrish, nor the

⁶⁸ Mr Morrish told us that the Treatment Centre and A&E are in different directions from their house (and so they would not have had to drive past the treatment centre to get to A&E).

Surgery, were invited to this meeting. The Surgery told us that it had not even been aware the meeting had taken place until Mr Morrish told them about it.

163. Mr Morrish told us that he did not receive the documents he requested. He said that the independent investigation was *'incomplete'* and *'shoddy'*, and *'fizzled out into nothing'*. The Chair told us that it was his decision to end the second investigation. He said that although Mr and Mrs Morrish had a number of concerns following the investigation report, he tried to explain to them that his role was not to get to the bottom of everything, but to get the organisations involved in Sam's care to acknowledge and recognise what went wrong; to learn from what happened; and to implement change. He told us that he had explained to Mr and Mrs Morrish that he felt the investigation had met the terms of reference and it was necessary to draw a line under the process. He acknowledged that, in hindsight, the terms of reference agreed at the meeting of 28 June were not sufficient, and a much more robust investigation was required. With regard to the meeting on 30 September, the Chair could not recall why the Surgery was not invited.

164. Mr Morrish contacted the PCT on 19 September, asking how it would resolve his concerns about whether any of the organisations would learn, improve and put things right. Mr Morrish told the PCT that the report produced by the two independent investigators was blinkered and relied too much on the information contained in the individual organisations' reports. The PCT agreed to look at Mr and Mrs Morrish's concerns about the

independent investigation, and began to appoint a further independent investigator, whom it would fund. Mr Morrish wanted to know whether a further independent review would address his ongoing concerns, and questioned whether there could truly be an *'independent'* investigator, even one who was an ex-NHS employee and from outside the region. He asked whether the PCT could assure him that the investigator would be *'free to speak their minds'* when they were being paid to *'do a job for the NHS'*.

165. In order to assure Mr and Mrs Morrish that a new investigation would be independent, the PCT arranged for them to meet the investigator in January 2012. Mr and Mrs Morrish were accompanied to the meeting by three representatives from the Patients Association (who had been asked to attend by the PCT to try and address the family's accusations of bias). After the meeting, Mr and Mrs Morrish remained unconvinced that a new investigation would properly address their concerns as the investigator *'refused to offer any evidence of her capacity or capability to conduct an investigation'*. They declined the PCT's offer of a third investigation.

166. The Patients Association told the PCT that to ensure a full and independent investigation, the matter should be referred to our Office. Mr and Mrs Morrish explained to us that the Patients Association told them that *'their only option thereafter was to bring [their] complaint to [us]'*. This was jointly agreed between the PCT, Mr and Mrs Morrish, and the Patients Association on 13 February.⁶⁹ On 2 March the PCT wrote to all the organisations to tell them that the third

investigation was to be stopped and the case was to be sent to us to investigate.

Mr and Mrs Morrish's access to bereavement support

167. Mr Morrish told us that after Sam died, it was down to him to seek bereavement support for his family. He said it was a *'bleak'* and *'very lonely'* time.

168. The family's allocated GP met Mr and Mrs Morrish on 17 January, on her return to work after an absence. She discussed with them the types of support that might be available. Mr and Mrs Morrish said that it was during this meeting that they also asked for help for Sam's brother. The family's allocated GP told us that she gave Mr and Mrs Morrish information about Cruse,⁷⁰ and a children's hospice and gave them a book that was written to help bereaved children.⁷¹ On 8 March the Surgery contacted Mr and Mrs Morrish and gave them details of charities who could offer support. After the family confirmed that they might have access to private funding for counselling (through insurance policies), the Surgery said it would speak to the paediatric consultant to see who he would recommend.

169. In mid March the practice manager at the Surgery contacted the Trust's paediatric consultant to ask whether private counselling was available for Mr and Mrs Morrish. Over the next few days, there were discussions between the Surgery and the paediatric consultant about arranging counselling until, on 1 April, the paediatric consultant referred Mr and Mrs Morrish to

a senior psychologist at the Trust, whom they saw shortly afterwards. Mr Morrish says that the referral to a psychologist was not *'volunteered'* by the Trust, but only happened after they had persistently requested help from the paediatric consultant, and then the surgery.

170. In response to concerns Mr Morrish raised with the PCT during April about the lack of bereavement support for his family, the PCT sent details of bereavement services to the Trust and the Surgery. The Surgery contacted Mr Morrish to discuss the possibility of seeing a private counsellor. As Mr Morrish had not heard anything further about access to the private counsellor, he contacted the Surgery on 9 May. He realised that his family's details had not been passed to the counsellor, and when Mr Morrish himself spoke to the counsellor, a counselling session was arranged almost immediately.

171. Mr and Mrs Morrish told us that although the Surgery gave them some information about support for Sam's brother during the allocated GP's visit, this was insufficient. At the end of May, Mr Morrish contacted the PCT because he was unhappy that Sam's brother had not received bereavement support since Sam's death, despite them requesting help from the Trust for him on 17 January, and support from the Surgery on 25 January. The team agreed that a package of care would be offered to the family, and contacted the charity Balloons.⁷² On 14 June the public health nursing team visited Mr and Mrs Morrish to discuss support for Sam's brother. The team

⁶⁹ The PCT told us that before the involvement of the Patients Association, it was not aware that it could have referred Mr and Mrs Morrish's concerns to us because, at that point, it did not consider that the family had made a formal complaint.

⁷⁰ Cruse offers specialist website, telephone, email and face-to-face support for adults, children and young people who are bereaved.

⁷¹ A short story picture book for children about grief.

⁷² The charity supports children and young people to address the effects of bereavement. Mr Morrish has told us that, at the time, Balloon's services did not cover their area.

explained that Sam's brother could access the services of the child and adolescent mental health services immediately if required. The family also accepted help for Sam's brother from Winston's Wish, but mentioned the difficulties they were facing in finding ongoing support for themselves.

172. On 30 June the Surgery contacted the PCT to discuss counselling sessions for the family. It said that whilst Mrs Morrish was receiving counselling, it would soon end as the family's insurance only covered a limited number of sessions. On 5 July the Surgery emailed the PCT asking if it would fund four more sessions. The Surgery told Mr Morrish that it was waiting for a response from the PCT. Mr Morrish told the Surgery that he thought funding would be for the Surgery to decide.
173. In mid-July the PCT told the Surgery that funding would be provided for four sessions of counselling for Mrs Morrish. The Surgery called Mr Morrish to tell him the news and, although pleased, he explained that he did not know how many more sessions he and his family might need or how future sessions might be funded. Mr Morrish said that the impression he had being given previously was that funding would not be a problem, but now it appeared that whether his wife would receive any further counselling was a 'lottery'.
174. The family continued to receive counselling from July onwards. Throughout November, Mr and Mrs Morrish remained in contact with the PCT, discussing ongoing bereavement support for the family. During this period, Mr Morrish said he had the impression that someone was putting the counsellors under pressure to reduce the

number of sessions his wife was receiving. The PCT said it was not aware that anyone was applying any pressure, and explained that funding was still in place.⁷³ Counselling ended in January 2012.

175. Mrs Morrish also told us that, with regard to the actions of the Surgery, around the anniversary of Sam's death, they 'ensured ... we knew how to access their services to avoid having to go into [their premises] in the week running up to Christmas ... this arrangement was both considerate to us, but also not asked for by us, it was unprompted'. She added that in the period following Sam's death:

'The lead GP followed up appointments where [Sam's brother] was ill to make sure that we were not anxious about him and to let us know he was available if we needed that support. The Surgery made alternative arrangements for me so I didn't have to see a GP in the same room where I last took Sam. The First, Second and lead GP showed genuine remorse for what had happened. They spoke to us with sympathy and consideration. Yes ... they failed when it came to arranging formal support, but in all other respects their contact with us was sympathetic and considerate.'

⁷³ The PCT told us that there was never any question that it would not provide ongoing funding for Mrs Morrish's counselling sessions.

Annex B: Mrs Morrish's narrative of events

A Narrative account of the events leading up to the death of Samuel Morrish on 23rd December at 5am by Susanna Morrish (1st April 2011).

w/c 19th December 2010: Introduction

The week before Christmas, when it seemed all of the UK was frozen, everyone in the house (apart from me) caught Flu. We now know this was Flu B. Mostly it appeared like a very nasty cold but as always Sam got it worse than everyone else. For several days I was struggling to control his temperature which would shoot up to 39.5 with alarming regularity. I embarked on a regular routine of dishing out Calpol and Ibruprofen, which would mean that despite his illness, he would perk up for an hour or so throughout the day, play with lego, watch a dvd or play rough and tumble with his brother - one such incident ending up with one of Sam's big nosebleeds. After a couple of days of Sam being ill, his big brother was getting better, but Sam was definitely getting more poorly and had a really nasty sounding cough, it would stop him sleeping and he was waking up a lot in the night coming to find me. (As Scott was also ill he was sleeping down stairs). On the Monday Sam was **violently sick** twice in the night and I thought it was time to take him to the GP. We made an appointment for Sam's brother, Scott and Sam all to see the duty doctor. I was concerned that Sam may have developed a chest infection - his history showed that he never got a nasty cold/ cough that didn't turn into an infection and he would also get very wheezy. As far as I was concerned it was just a matter of time before this happened... Sam had also been complaining of a lot of **tummy pain** which I thought may be down to the really persistent, never-ending cough.

When the duty doctor (the First GP) saw Sam and examined him he said there was no sign of a chest infection. He was a "very poorly boy" but it was just the same virus that everyone else had at the moment. However, as it was nearly Christmas he'd give us a prescription for anti-biotics, just in case it did turn into a chest infection, but there was no need for them at the moment. I accepted this as, although Sam was, in my eyes, very poorly with his cold, he was still behaving within my understanding and experience of how he was when he was ill. I didn't want to give him anti-biotics if they were unnecessary, although I didn't feel entirely confident as to how I should determine when they would become necessary, as his chesty cough already sounded pretty bad to me.

AM Wednesday 22nd December: Call to the Surgery

Sam didn't wake up the following night and wasn't sick again, but shortly after he woke in the morning I started to feel something was wrong. He only ate 2 teaspoons of breakfast, and even throughout his days of feverishness and sickness I'd always managed to persuade him to eat something. (He was still complaining of **tummy pain**). But more than that he just looked so ill. He had no colour at all, was very pale and had **no interest in anything**. I gave out the normal doses of calpol/ ibuprofen and expected him to have a little "brighter" patch as the medicine kicked in, as would be normal. But normal didn't happen. He just lay on the sofa drifting in and out of sleep, not interested in what his brother was playing, not interested in a dvd...just **really thirsty**. He wouldn't put his drink down.

About 10.00 I took him to the toilet where he did a tiny wee and I decided it was best to keep him in a nappy as he was sleeping so much. (Sam had been potty trained for well over a year, but still wasn't dry at night.) It was around this time that I called the GP and

got through to the Triage Nurse. I explained that Sam had seen the First GP the day before and that the Dr had described him as a “very poorly boy” but that Sam seemed so much worse today. And it was odd because his very high temperature had settled down to around 37.5, but “he seemed so much more ill”. It was like “**he was here but not here**” and “wasn’t interested in anything” and “was just drifting in and out of sleep”. The duty Doctor (Johnson) called back and I again tried to explain that Sam seemed really poorly and that I was worried about him. I was also worried about getting out in the snow/ ice with two sick children and a sick husband. An appointment was made to bring Sam into the surgery for 4pm that afternoon.

With the description of Sam’s symptoms, should it have highlighted a possible risk of Meningitis/ Septecemia?

... and in that context should an appointment have been made for a time earlier in the day?

Wednesday 22nd December: Duty Doctor Appointment at the Surgery

We arrived at the Surgery just before 4pm and I sat waiting with Sam on my lap, with him half drifting in and out of sleep. Every now and again he would cough his hacking cough and take sips of water. After we had waited for 10 minutes I started to get increasingly anxious about Sam, I felt tearful and exhausted, having no idea how much longer we had to wait, not knowing what to do. When we were called, Sam was asleep, he woke up when I carried him into the room. I tried to explain the dramatic change in him over the last 24 hrs, the symptoms of “here but not here”, that he wasn’t interested in anything, he was really thirsty, had tummy pain, a never ending hacking cough and he just “looked” so much more ill. It also seemed really odd that his temperature had gone down, yet obviously he appeared more ill. Sam was examined by the Dr who

asked if he was weeing OK. I responded he’s been in a nappy all day. I was trying to explain that he was too ill for me to expect him to go to the toilet, even though he had been potty trained for over a year. The nappy wasn’t checked to see if he had been weeing or not,

We were sent home with a prescription for some cough syrup. I didn’t have any information about who to ring or what to do if he deteriorated later in the day.

Why wasn’t the nappy checked when oliguria (low output of urine) is a symptom of septicaemia? Surely just checking for hydration isn’t enough?

Was the GP aware that other symptoms Sam was showing are indicators of septicemia e.g. Tummy Pain, extreme thirst, fever, vomiting, paleness, very sleepy?

Why weren’t we given information about what to do “out of hours” “NICE guidelines on ‘Feverish Illness in Children’ highlight the importance of a safety net when a febrile child is sent home. This includes..., advising on accessing further healthcare.”

Wednesday 22nd December 6pm-9pm: Calls to NHS Direct/ from Devon Doctors

We got back from the Surgery shortly after 5.00, Sam wouldn’t eat any tea but was till very thirsty and continually sipping his water. He sat to my lap and said his tummy was hurting and was sick into a bowl (about 6pm). Looking at it I thought something wasn’t right, there were tiny black streaks in the clear liquid, which looked to me like they could have been blood. I felt worried so phoned the Surgery, when I heard, “The surgery is now closed” I phoned NHS direct. I explained to the lady about my concern for the vomit and she asked several questions which included asking us to check Sam’s Nappy. It was completely dry. It was at this point we realised that he hadn’t weed

since 10am. The NHS direct lady seemed very concerned about this, more so than about the vomit, and said that someone from Devon Doctors would call us back. Shortly after this Sam went to bed and was instantly asleep. An hour after speaking to NHS direct, about 7pm whilst I was getting my other son out of the bath, the phone rang, I ran to it but it cut off when I picked it up. I did 1471. The number was with-held. I still don’t know if this was Devon Doctors on not.

I thought , if it was the doctors they will try phoning back in a minute... but by 8.30 there had been no other call. I was really anxious for Sam and re-phoned NHS direct to ask again for someone to call me. I hadn’t been given any information as to how to contact the doctors directly. Shortly after this my husband called out to say that Sam had been sick again and this time it was all black. He was vomiting blood. We rushed to get ready to take Sam somewhere, we assumed he would be going to a hospital, but were waiting to be told where to go. I think someone then called back (Devon doctors?) and advised us to take Sam to Newton Abbot Devon Doctors, “as that would be the quickest way of getting prioritised at Torquay A+E”.

Did any one from Devon Doctor’s ring back after our call to NHS direct at 6pm? If they did, (and the missed call at 7pm from a withheld number was them) why didn’t they try again?

The NHS direct nurse we spoke to at 6pm seemed very concerned that Sam hadn’t wet his nappy since 10am- why wasn’t the follow up call to us from Devon Doctor’s prioritised? Even waiting a hour seems a long time.

When we spoke to someone shortly before 9pm, just after Sam had vomited blood, we were advised to go to Devon Doctors at Newton Abbot hospital- why were we sent there instead of straight to A+E? Should we have been told to ring 999?

Wednesday 22nd December: Arrival at Devon Doctors/ Newton Abbot Hospital When we arrived at Newton Abbot we went to the reception, who said they were expecting Sam, but we were then told to take a seat and wait as there were three people in front of us. I didn’t understand why no-one was checking him first to see how ill he was. I sat down with Sam, but after 15 minutes became increasingly distressed at his condition. Apart from the person at reception there had been no-one else to talk to, but suddenly a nurse passed by and I simply said, “please help”. And she took us into a side room. 10 minutes later we were in an Ambulance being rushed to Torquay.

We were given the impression that Sam would get into Torbay faster if he was seen by Devon Doctors first, but when we arrived we were told there were three people in front of us and that we had to wait, why, why, why? Had no-one communicated to the reception what his symptoms were? Is it normal to make 3 year olds who haven’t weed for almost 12 hours and who are vomiting blood to wait in a queue?

Wednesday 22nd December: Arrival at Torquay Hospital

I understand that the treatment and tests at Torbay hospital have been well documented however there are a few points we would like to make. Shortly after arrival, we explained to one of the registrars that Sam had been seen by the duty doctor at 4.30pm and sent home, and that the doctor had examined Sam and said his lungs were clear. 5 hours later an xray showed, one lung completely full/ white. The assumption of the registrar was that the GP had made a mistake, “what was the GP thinking of sending us home?”. Rather than thinking if the lungs were clear at 4.30pm, and are now full, how quickly is Sam’s condition deteriorating? Focus was put on treating the pneumonia, rather than vomiting blood, as Sam didn’t appear to have any abdominal

tenderness. The paediatric consultant has also noted that there was a 1 and a 1/2 hour delay between Sam's arrival and the administration of anti-biotics. They weren't given until Sam arrived in HDU when they should have been given in A+E. Septicemia is described as a "race against time", every minute counts. By 5am on the 23rd December Samuel had died from Septic Shock.

The fact that we visited the hospital out of hours meant that there was no ability to check the details of Sam's earlier appointment with the GP. Why?

Was the assumption made that the GP didn't hear a chest problem that was there?

If they hadn't made that assumption would they then have realised how quickly Sam had deteriorated in the last few hours? Would that have affected the treatment he received?

Why was there a delay in the administration of antibiotics?

When did the doctors at Torbay start to suspect septicemia?

And why were the 'known' symptoms of Septicemia not recognised?

Septicemia is described by Meningitis Research as a "race against time" but the treatment and contact Sam had with the NHS throughout the 22nd December was subject to delays with every agency which he came into contact with.

Annex C: The relevant standards in this case

Our Principles

1. Our Principles of Good Administration, Principles of Good Complaint Handling and Principles for Remedy are broad statements of what public organisations should do to deliver good administration, provide good customer service and respond properly when things go wrong.⁷⁴
2. Two of the Principles of Good Administration are particularly relevant to this complaint:
 - 'Getting it right' – which includes acting in line with the public organisation's policy and guidance (published or internal); taking proper account of established good practice; and taking reasonable decisions, based on all relevant considerations.
 - 'Being customer focused' – which includes responding to customers' needs flexibly, including, where appropriate, co ordinating a response with other service providers.
3. Four of the Principles of Good Complaint Handling are particularly relevant to this complaint:
 - 'Being customer focused' – which includes dealing with complainants promptly and sensitively, bearing in mind their individual circumstances; listening to complainants to understand their complaint and the outcomes they are seeking; and responding flexibly, including co-ordinating responses with

any other organisation involved in the same complaint, where appropriate.

- 'Being open and accountable' – which includes providing honest, evidence based explanations and giving reasons for decisions.
- 'Acting fairly and proportionately' – which includes ensuring that complaints are investigated thoroughly and fairly to establish the facts of the case; and that complaints are reviewed by someone not involved in the events leading to the complaint.
- 'Putting things right' – which includes acknowledging mistakes and apologising where appropriate; and providing prompt, appropriate and proportionate remedies.

Good Medical Practice

4. The General Medical Council (the GMC – the organisation responsible for the professional regulation of doctors) publishes *Good Medical Practice* (Good Medical Practice), which contains general guidance on how doctors should approach their work, and represents standards that the GMC expects doctors to meet. It sets out the duties and responsibilities of doctors and describes the principles of good medical practice and standards of competence, care and conduct expected of doctors in all areas of their work. Section two states that good clinical care must include:
 - '(a) adequately assessing the patient's conditions, taking account of the history (including symptoms, and psychological and social factors), the

⁷⁴ You can download PDF versions of our Principles at www.ombudsman.org.uk/improving-public-service/ombudsmansprinciples.

- patient's views, and where necessary examining the patient
- (b) providing or arranging advice, investigations or treatment where necessary
- (c) referring a patient to another practitioner, when this is in the patient's best interests.'
5. Section 29 states that doctors must:
- 'be considerate to relatives, carers, partners and others close to the patient, and be sensitive and responsive in providing information and support, including after a patient has died.'*
- ### Feverish Illness in Children
6. The National Institute for Health and Care Excellence (NICE) is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health. In May 2007 NICE published *Feverish Illness in Children* (Feverish Illness in Children), which set out guidance that should be followed when assessing and managing children younger than five years old who have a feverish illness. It states that *'children with feverish illness should be assessed for the presence or absence of symptoms and signs that can be used to predict the risk of serious illness using the traffic light system'*.
7. The 'traffic light system for identifying likelihood of serious illness' in the Feverish Illness in Children lists 'green – low risk', 'amber – intermediate risk' and 'red – high risk' signs and symptoms. 'Amber' symptoms include:
- decreased activity
 - nasal flaring⁷⁵
 - respiratory (breathing) rate of more than 40 breaths per minute (for children over 12 months old)
 - capillary refill time⁷⁶ of three or more seconds
 - reduced urine output; and
 - fever for five or more days
8. 'Red' symptoms include:
- no response to social cues
 - unable to rouse, or if roused does not stay awake, and
 - respiratory rate greater than 60 breaths per minute
9. Feverish Illness in Children also list a number of 'key priorities for implementation', which include:
- 'Detection of fever*
- *'In children aged 4 weeks to 5 years, healthcare professionals should measure body temperature by one of the following methods:*

⁷⁵ Nasal flaring is when the nostrils widen while a person is breathing. It is a sign that the person is having difficulty breathing. It is most commonly seen in children and infants; in those cases, nasal flaring can indicate respiratory distress.

⁷⁶ A capillary refill test measures the time taken to refill the very small blood vessels in the body. It is used to measure whether someone is dehydrated. A refill time of less than three seconds is considered normal, whereas a time greater than this indicates increasing degrees of dehydration.

- *electronic thermometer in the axilla [the armpit]*
 - *chemical dot thermometer⁷⁷ in the axilla*
 - *infra-red tympanic⁷⁸ thermometer*
- *'Reported parental perception of a fever should be considered valid and taken seriously by healthcare professionals*
- 'Clinical assessment of the child with fever*
- *'Healthcare professionals should measure and record temperature, heart rate, respiratory rate and capillary refill time as part of the routine assessment of a child with fever.'*
10. The Feverish Illness in Children guidelines state that a raised heart rate can be a sign of serious illness, particularly septic shock.
11. The Feverish Illness in Children guidelines explain what 'safety nets' should be put in place for patients or carers. It states if any amber features of the traffic light system are present, and no diagnosis has been reached, healthcare professionals should:
- *'Provide the parent or carer with verbal and/or written information on warning symptoms and how further healthcare can be accessed*
 - *'Arrange a follow-up appointment at a certain time and place.*
 - *'Liaise with other healthcare professionals, including out-of-hours*
- providers, to ensure the parent/ carer has direct access to a further assessment for their child.'*
- ### National Quality Requirements in the Delivery of Out-of-Hours Services
12. In October 2004 the Department of Health published the *National Quality Requirements in the Delivery of Out-of-Hours Services* (the Quality Requirements), which set out standards to be met by out-of-hours service providers. Requirement 7 states:
- 'Providers must demonstrate their ability to match their capacity to meet predictable fluctuations in demand for their contracted service, especially at periods of peak demand, such as Saturday and Sunday mornings, and the third day of a Bank Holiday weekend. They must also have robust contingency policies for those circumstances in which they may be unable to meet unexpected demand.'*
13. Requirement 9 states:
- 'Definitive Clinical Assessment*
- 'Providers that can demonstrate that they have a clinically safe and effective system for prioritising calls, must meet the following standards:*
- *'Start definitive clinical assessment for urgent calls within 20 minutes of the call being answered by a person*
 - *'Start definitive clinical assessment for all other calls being answered*

⁷⁷ A thermometer bonded to a plastic strip that indicates a patient's temperature using colour changes.

⁷⁸ A thermometer used to record the patient's temperature in their ear.

within 60 minutes of the call being answered by a person.⁷⁹

14. Requirement 10 states:

‘Face to face clinical assessment

‘Identification of immediate life threatening conditions

‘Providers must have a robust system for identifying all immediate life threatening conditions and, once identified, those patients must be passed to the most appropriate acute response (including ambulance service) within 3 minutes.’

Surviving Sepsis Campaign: Guidelines for management of severe sepsis and septic shock

15. *The Surviving Sepsis Campaign: Guidelines for management of severe sepsis and septic shock* (the Sepsis Guidelines) are the international guidelines for managing patients with severe sepsis and septic shock. They were published in January 2008 by the Surviving Sepsis Campaign. The Sepsis Guidelines describe how severe sepsis should be treated. They state that intravenous antibiotics should be administered as early as possible and always within the first hour of recognising severe sepsis and septic shock. Blood cultures⁸⁰ should be taken for analysis, and the specific source of the infection should be established as rapidly as possible and within the first six hours following

presentation. Prompt antibiotic treatment should be provided with broad-spectrum antibiotics⁸¹ until the results of blood cultures identify the specific type of antibiotics to be given, and fluid therapy should be commenced (the medical practice of replenishing bodily fluid in order to maintain blood volume).

Standards for the care of critically ill children (4th edition)

16. In June 2010 the Paediatric Intensive Care Society (PICS) published the fourth edition of its *Standards for the care of critically ill children* (The PICS Guidelines). The PICS Guidelines inform the structuring and developing of paediatric intensive care services in the UK and explain when patients should be referred to a paediatric intensive care unit. They state that ‘paediatric intensive care admission is mandatory for patients likely to require advanced respiratory support’ or if they ‘have symptoms or evidence of shock, respiratory distress or respiratory depressions’ or ‘have an acute organ (or organ system) failure’.

Record Keeping: Guidance for Nurses and Midwives

17. The Nursing and Midwifery Council (the NMC – the organisation responsible for the professional regulation of nurses) publishes *Record Keeping: Guidance for nurses and midwives* (the NMC Guidance). The NMC

Guidance explains how record keeping is an integral part of nursing, helping to provide safe and effective care to patients. The 2009 edition, which was in place at the time Sam was ill, states that nurses’ records ‘*should be accurate and recorded in such a way that the meaning is clear*’. It also states that nurses ‘*should use [their] professional judgement to decide what [information] is relevant and what should be recorded*’.

Paediatric early warning score escalation plan

18. At the time of Sam’s admission to hospital, the Trust was piloting a paediatric early warning score escalation plan (the Escalation Plan), which detailed the actions nurses should take depending on a patient’s paediatric early warning score.⁸² It stated:

‘0 or 1 - Continue monitoring

2 - Inform Nurse in Charge and SHO [junior doctor] Review

3 - Senior Nurse and Paediatric Review

4 - Urgent Paediatric Registrar [middle grade doctor] Review and Inform Consultant [a senior doctor]. Consider informing Outreach Team⁸³

5 or more - Paediatric Consultant review. Request Anaesthetic review and

outreach team (Anaesthetic Registrar must discuss with consultant).’

19. The Escalation Plan does not set out timescales for taking these actions.⁸⁴

When a patient dies - Advice on developing bereavement support in the NHS

20. In October 2005 the Department of Health published *When a patient dies – Advice on developing bereavement support in the NHS* (the Bereavement Guidelines). The Bereavement Guidelines describe the basic elements required to provide appropriate bereavement services to people who are bereaved. They set out a number of principles that should underpin bereavement services. These state:

‘The following principles underpin the development of services and professional practice around the time of a patient’s death and afterwards. They apply equally to the care and support of the patient before death and the subsequent support of the partner, family, relatives and/or others who are bereaved ... The principles are of especial significance for particular groups, such as those suddenly bereaved from unexpected and/ traumatic death [and] those whose child dies.

79 In 2006 the Department of Health published clarification of the Out-of-Hours Guidelines. They explained that requirement 9 would be classed as having been fully complied with if a definitive assessment was started within 60 minutes for 95% (or above) of calls passed to an out-of-hours service provider.

80 Blood cultures are used to detect bacteria or yeast in the blood, to identify any micro-organisms present and to guide treatment.

81 Antibiotics that act against a wide range of disease-causing bacteria. The Sepsis Guidelines state that although ‘restriction of antibiotics as a strategy to reduce the development of ... resistance ... is not an appropriate initial strategy’, once the bacteria causing sepsis has been identified, specific antibiotics should be given instead.

82 Paediatric early warning scores indicate whether a child’s condition is deteriorating or improving. The score is generated by reviewing seven physiological observations – temperature, heart rate, blood pressure, respiratory rate, respiratory distress, oxygen saturation levels, and the patient’s level of consciousness. If an observation is normal, a score of zero is recorded. If it is abnormal, a score of 1 is recorded. The scores are added together to give a total score out of seven. Depending on the total score, staff are required to take specific actions.

83 A team made up of doctors and nurses with intensive treatment experience. Outreach teams support ward staff caring for acutely unwell patients on the ward and/or facilitate transferring the patient to an intensive care unit or a high dependency unit.

84 The Trust has provided us with its revised Escalation Plan, which now includes timescales for taking actions depending on the paediatric early warning score.

- ‘Communication – communication with people around the time of a death and afterwards should be clear, sensitive and honest.
- ‘Information – people who are dying, and those who are bereaved, need accurate information, appropriate to their needs, communicated clearly, sensitively and at the appropriate time (the role of the voluntary sector can be of particular importance here).
- ‘Partnership – when a patient dies, services should be responsive to the experiences of the patient and people who are bereaved; these experiences should inform both service development and provision. In one-to-one contact, patients and families should be enabled to express their needs and preferences, through sharing expertise and responsibility and facilitating informed choice.
- Recognising and acknowledging loss – people who are bereaved need others to recognise and acknowledge their loss. Recognition by professionals, appropriately expressed, may be especially valued. Professionals should be aware of the importance of time and timing and should try to work at the pace dictated by people’s feelings and needs.’

Being Open

21. In July 2010 the Trust produced guidelines entitled *Being Open* for staff on what to do if a patient suffered serious harm or died as the result of an adverse event. Section four explained that a formal meeting should be arranged with relatives

‘as soon as possible after the incident’ and with the ‘most senior person responsible for the patient’s care’. The guidance also explains what should happen following the meeting, including that:

- ‘The contact person should maintain a dialogue with the patient and/or carers.
- ...
- ‘The contact person should give the patient or carer information on counselling or support services available locally or nationally which may offer appropriate help.’

Annex D: Advice from our clinical advisers

1. As I explained in paragraph 18, in the course of our investigation, we sought clinical advice from seven of our clinical advisers.

The GP Adviser

2. The GP Adviser said that Sam was a previously healthy three-year-old boy who had a history of chest infections, but who was brought to the Surgery on 21 December because of a fever and a ‘really vicious’ cough he had had for a week. He had also vomited during the previous two evenings. She said that the First GP should have taken a clear history of Sam’s condition, and, based on Feverish Illness in Children assessed whether to reassure Mrs Morrish, give her clear advice about how to monitor Sam’s condition, or admit Sam to hospital. The GP Adviser said that based on Mrs Morrish’s description of what had happened and the clinical records, Sam had at least one amber feature at this visit in that he had had a fever for more than five days. She added that although the traffic light system does not list heart rate as an indicator of serious illness, other parts of the Feverish Illness in Children do, and they state that a child’s heart rate should be measured. If it is raised, it can be an indicator of septic shock. However, the First GP did not record Sam’s heart rate. The GP Adviser said that if the First GP had felt it appropriate not to admit Sam to hospital, he should have given clear instructions to Mrs Morrish about what to do if Sam deteriorated, including warning signs to look out for. The advice should have included that if Sam

became lethargic or pale, or deteriorated, immediate advice should be sought.⁸⁵

3. The GP Adviser said that when the Second GP spoke to Mrs Morrish by telephone the following day, he should have carefully assessed how urgently Sam needed to be seen. The GP Adviser said that Mrs Morrish had described how lethargic Sam was – she told the nurse practitioner that he was lethargic and had no energy (he was ‘*here but not here*’) and the nurse practitioner passed this information to the Second GP (paragraph 30). The GP Adviser said that, based on this information, Sam now fitted the red criteria of the traffic light system. She added that Mrs Morrish should have been asked about Sam’s urine output, and if Mrs Morrish had told the Second GP that Sam’s nappy was dry, she should have been told to bring Sam to the Surgery immediately for an assessment.
4. When Sam was seen by the Second GP on 22 December, he should have been assessed according to Feverish Illness in Children, which means his heart rate, hydration levels and respiratory rate should have been measured. The GP Adviser added that although it should have been obvious to the Second GP if Sam had nasal flaring, it would not have been standard practice to record that this was not present. However, the GP Adviser said that Sam clearly fitted both the red and amber criteria of the traffic light system because he was falling asleep on Mrs Morrish’s lap in the waiting area (Annex B) and his urine output had fallen. She said that:

‘at this point, Sam should have been admitted immediately to the care of a paediatrician even if his chest was

⁸⁵ Mrs Morrish has explained that the First GP told her to bring Sam back to the Surgery if his condition deteriorated (paragraph 28), which she did the following day.

clear because his general condition was so much worse and he had stopped passing urine and had had a fever for more than a week.'

5. The GP Adviser said that:

'if Sam had been assessed as amber on 21 December, and Mrs Morrish specifically advised that if he had become worse in any way he must be reassessed urgently, then Sam might have been seen earlier on 22 December. If Sam had been seen earlier on 22 December, and been assessed as having criteria indicating serious illness (when roused does not stay awake), reduced urine output, fever longer than one week, he would have been transferred to hospital early on 22 December and received antibiotic treatment possibly 12 hours earlier than actually occurred.'

6. The GP Adviser acknowledged that GPs see a large number of children with feverish illness in the winter months and it is very rare for a GP to witness a patient with life threatening sepsis. However, she said that the Feverish Illness in Children had been published in order to give doctors 'a clear framework to identify children who are outside the normal range for feverish children'. She said that although some aspects of the guidance were reflected in what the GPs did, they had gathered insufficient information to fully inform their decisions about Sam's clinical management. She said the Second GP did not do enough, did not obtain enough evidence – including taking account of Mrs Morrish's concerns (including how sleepy Sam was) – to be in a position to adequately assess Sam's condition and to form a definitive diagnosis. If the Second GP had checked Sam's urine output, and taken proper account of Mrs Morrish's concerns, it would have been

good practice to refer Sam to hospital immediately.

7. With regard to the bereavement support offered to the Morrish family by the Surgery, she said:

'On reading Mr Morrish's account of the weeks after Sam's death, it is apparent that the lack of information and explanation about what had happened to Sam was very distressing. The first duty of a doctor is to put a patient's interests first. The Surgery should have contacted the family by telephone or letter shortly after Sam's death to offer an appointment with the GP of their choice either together or separately to discuss whatever they felt they needed to talk about. At these appointments, a full explanation of what happened to Sam should have been offered in an open and honest way. If Mr and Mrs Morrish did not immediately respond to the Surgery's invite, there should have been a recognition that they may be too shocked to respond and a further invite via telephone or letter should have been sent.'

'It is standard GP care to offer patients support during bereavement even in such tragic circumstances. A GP is expected to have certain generic listening skills which are very useful during early bereavement. Referral to other more specialist services should have been arranged promptly by the doctors at the Surgery if they felt that they did not have the necessary skills to give the Morrish family the care they needed.'

'The Morrish family were left without the necessary information to help them begin to understand how Sam

had died. They were left without information about the normal grieving processes and how they might affect them. They were left without the necessary information and referral to allow them to access specialist support for themselves. This would have increased their distress during the few months after Sam's death.'

'Although the GPs stated they did not have the necessary expertise to deal with bereavement counselling, the [family] should have been encouraged to attend the practice as a traumatic unexpected loss of a child would put them at risk of developing depression and anxiety. The [GPs] failed to encourage Mr and Mrs Morrish to attend when they felt ready or to make enquiries after their wellbeing despite having been so closely involved in Sam's last illness. This increased Mr and Mrs Morrish's distress.'

The NHS Direct Adviser

8. The NHS Direct Adviser explained that the health adviser who first spoke to Mrs Morrish should have asked her to confirm whether she had called the service before. This would have enabled the health adviser to check whether any important clinical information from previous calls was available. The NHS Direct Adviser said that although there was no formal policy for this in place when Mrs Morrish called NHS Direct, all health advisers would have been trained to ask about previous calls. The NHS Direct Adviser said that the health adviser's comment following Mrs Morrish's description of Sam's symptoms (*'I don't like that and I think it's best we get you talking to a nurse'*) was too casual, and comments like this should be discouraged. Nevertheless, he said

that he did not consider that the health adviser's actions affected the 'efficiency or safety of this call'.

9. Once the call was passed to the nurse adviser, the NHS Direct Adviser said, she chose the most appropriate algorithm for assessing Sam (*Vomiting, Toddler – Age 1 to 4 years*). He said that the nurse adviser should have asked Mrs Morrish to confirm whether Sam had symptoms relating to reduced levels of alertness. Although she recorded 'no' to whether Sam was 'floppy without muscle tone', 'unresponsive', 'could not be roused' or 'had cold and clammy skin', she did not ask Mrs Morrish whether Sam could be roused. The NHS Direct Adviser said that Mrs Morrish had clearly indicated that Sam was asleep, and the nurse adviser should have asked her to try and wake him to see if he was unconscious at the time. She did not.
10. The second question in the algorithm related to whether Sam had symptoms of meningitis. The nurse adviser answered 'no'. However, the nurse adviser should have checked details of how sleepy Sam was. The NHS Direct Adviser said that the nurse adviser could have answered 'no' to the question of whether Sam had meningitis, as long as she had made an on screen note to say that Sam was 'sleepy – has viral flu' or similar (as Mrs Morrish had already told her Sam was asleep), but she did not. He said a child can be sleepier than usual because of other types of infection, such as viral flu.
11. The NHS Direct Adviser said that the nurse adviser also answered the next question (about whether Sam had a distinctive rash) without having obtained enough information. He said that the nurse adviser's answer might have been influenced by the Second GP's assessment that afternoon, in which Sam was

diagnosed with a viral rash. The NHS Direct Adviser said:

‘whether the rash had been reviewed by a medical professional or not, the nurse adviser should have asked and answered the questions (relating to the symptoms of a rash) to correctly rule out worsening symptoms. This was not done.’

12. The NHS Direct Adviser said the nurse adviser answered the question about whether Sam had bile or blood in his vomit incorrectly. The nurse adviser answered ‘no’ to this question. He said that Mrs Morrish had described brown lumps, as well as streaks, in Sam’s vomit. The NHS Direct Adviser said that in a child of Sam’s age, a tearing in the lining of the oesophagus (the tube that carries food from the throat to the stomach) can cause blood in vomit, although he acknowledged that this was more common in people with prolonged retching – which did not apply to Sam. Nevertheless, he said that, based on the information the nurse adviser had, she should have recorded that Sam had vomited blood. He said:

‘In Sam’s case, he had not vomited since midnight, then vomited again eighteen hours later when the brown lumps were first seen. The nurse adviser did not seem concerned at this first episode, but asked Mrs Morrish to call back if it happened again. I believe that [the question about vomiting blood] should have been answered “yes” rather than waiting for a second call with the same or worsening symptoms.’

13. If the nurse adviser had answered ‘yes’, the algorithm she was using would have prompted her to send Sam to A&E as soon as possible. However, because she did not, the system prompted her to refer Sam to ‘Primary Care Services Same Day’. The NHS Direct Adviser explained that because Mrs Morrish had told the nurse adviser that his nappy was dry, she should have taken account of the indication that Sam was dehydrated, and considered arranging a face to face assessment.⁸⁶ The NHS Direct Adviser said:

‘Regardless of the answers to the algorithm questions ... a nurse adviser recommending any disposition needs to consider whether the disposition is appropriate as well as what is likely to happen next. ... referring Sam to the GP might have been appropriate for the symptoms of dehydration alone, but the nurse adviser needed to use their clinical experience and knowledge to decide whether the disposition was appropriate for all the symptoms. For a child who seems to be vomiting amounts of blood, with a fever, fast and shallow breathing and has not passed urine for eight hours [she should have considered] whether a more urgent disposition [was] appropriate.’

‘The nurse adviser could have altered the disposition to “refer to primary service urgent”, which would require a quicker (0-2 hours) response from the out-of-hours GP. However, when referring to a GP, at any time of the day, the nurse adviser needed to consider what the GP can do with the

facilities available to them. In this case, the nurse adviser needed to decide whether the GP could improve the condition of the patient from their surgery or would they simply provide a face to face assessment, potentially duplicating the nurse’s questioning and resulting in a delay to the patient’s admission to hospital.

‘In this case, I believe that delays were caused by recommending a non-urgent GP referral, when the nurse adviser, using her experience and knowledge, could have foreseen that investigations and intravenous fluids may have been required. This is not something that can be provided by a GP at an out of hours surgery, and a disposition of Accident and Emergency would have been more appropriate.’

14. In summary, the NHS Direct Adviser said that had the nurse adviser recommended that Sam should go to A&E:

‘not only might the call length have been shorter due to the urgency of the outcome, but the Morrish family could have travelled directly to A&E (at the Trust). Instead of arriving by ambulance (at approximately 10.30pm), Sam could have arrived sometime before 7.30pm. It is therefore possible that a paediatrician could have assessed Sam in A&E some three hours sooner.’

The Out-of-Hours Adviser

15. The Out-of-Hours Adviser said that NHS Direct is a nationally-recognised triage service, working to approved algorithms. Therefore, the information the NHS Direct nurse adviser passed to Devon Doctors Ltd constituted a clinical assessment. Included in that information was a reference to Sam not having urinated since morning. The

Out-of-Hours Adviser said that this was a ‘risk factor however, they would also have known that NHS Direct had done a triage assessment and given the case a routine priority. There is nothing else in NHS Direct’s record that would have caused the GPs a higher level of concern’. She added that:

‘As the two GPs at Devon Doctors Ltd only had NHS Direct’s information to rely on, it was reasonable for them to assume this was accurate and it is fair to say this [information] did not signify any serious clinical concerns. It is easy with hindsight and the knowledge that is now available (that the NHS Direct nurse adviser in fact did not accurately record Sam’s history) to be critical of the GPs at Devon Doctors Ltd, but if it is examined in the context of what they were presented with, Devon Doctors Ltd’s response is perfectly reasonable and justified.’

16. The ‘routine’ nature of the referral from NHS Direct to Devon Doctors Ltd meant that the GPs had to begin a definitive clinical assessment within 60 minutes of the call being answered. The Out-of-Hours Adviser said:

‘in practice, when a call has come via NHS Direct, the 60 minutes start from when the call is transferred from NHS Direct to the out-of-hours provider. So in this case Devon Doctors Ltd should have called Mrs Morrish by 7.44pm, 60 minutes after the call was made.’

She added:

‘The failure to speak to Mrs Morrish within the 60 minutes from receiving the call at 6.44pm does breach the definitive clinical assessment as set out in the National Quality Requirement

⁸⁶ In April 2009 NICE published *Diarrhoea and vomiting caused by gastroenteritis: diagnosis, assessment and management in children younger than 5 years*. It states that healthcare professionals carrying out a ‘remote assessment’ (for example, by telephone) should refer children with symptoms of dehydration for a face-to-face assessment. It says symptoms of dehydration include a child ‘appears to be unwell or deteriorating’, is ‘lethargic’, and has ‘decreased urine output’.

9, which refers to telephone clinical assessments ... However, the Department of Health allow a 95% standard as it is deemed unreasonable to expect 100% of calls to be answered in 60 minutes, and an example of this is when a phone back is not answered as occurred in this case.'

17. The Out-of-Hours Adviser added that even if a GP had been able to speak to Mrs Morrish within 60 minutes, it cannot be presumed that they would have sent an ambulance or advised taking Sam directly to A&E because at that point, Sam had not vomited black liquid. She said that there is a range of possibilities for what could have happened. However, she acknowledged that had Mrs Morrish told the GP that Sam had earlier vomited blood (as she had told the NHS Direct nurse adviser), and that he had not urinated for over eight hours and was lethargic, then an ambulance should have been dispatched, or Mrs Morrish told to take Sam directly to hospital.

18. The Out-of-Hours Adviser said that there are no national standards or guidelines for out-of-hours providers about what should be done if a call to a patient/carer is not answered. However, the Out-of-Hours Adviser explained that it is established good practice that:

'the clinician tries to call three times within the 60 minute time frame. If contact is not made the case is returned to the call centre for investigation. The call centre then use a variety of methods to verify the phone number given, call round the nearest hospitals and walk in centres to see if the patient has presented elsewhere, and finally will assign the case a home visit if all attempts to contact the

patient or family have failed. If Devon Doctors Ltd had followed such a procedure, it is reasonable to assume that Sam would have been assessed face to face sooner, however it is impossible to predict how much sooner or whether the outcome would have been different.'

19. The Out-of-Hours Adviser said Devon Doctors Ltd did not appear to have a policy in place for clinicians to follow in circumstances in which calls go unanswered. She said that:

'It is fair and reasonable for Devon Doctors Ltd to highlight that the GPs were very busy, that evening and it is fair and reasonable that it would not be usual for a doctor to call back every five minutes ... as the doctors had other calls and patients to deal with. However, this is not a defence for not having a robust policy for managing unanswered calls.'

20. The Out-of-Hours Adviser said that after his first attempt to call Mrs Morrish, the GP at Devon Doctors Ltd did not 'lock' the call. 'Locking' the call would have prevented the other doctor on shift from accessing the call. She said that this was appropriate because it allowed both doctors to have equal access and equal responsibility for speaking to patients. The Out-of-Hours Adviser said that:

'When Mrs Morrish called back at 8.52pm, it would appear that the call was taken by a call handler at control, which is reasonable. What is not acceptable is the fact that this call did not seem to trigger any escalation, there is no record of the call, and it does not appear that the call handler informed the GPs of the breach [that a

*definitive assessment had not happened within 60 minutes] in this case.'*⁸⁷

21. With regard to the call from Mrs Morrish at 9.08pm, the Out-of-Hours Adviser said that:

'The call handler stated to Mrs Morrish that he recognised the urgency of the situation and would spend a few minutes ascertaining the most appropriate place for Sam to be seen and would ring back ... Given that this was a call from a concerned parent, there were new symptoms and the situation was obviously evolving and deteriorating, it is very reasonable to expect that the call was "flagged" to the clinicians straight away, especially as it had breached the 60 minute time period.

'[The computer system] has an instant messaging system that can quickly and easily alert all online users to a situation or query. Although it is not reasonable to expect non-clinical staff such as receptionists to make clinical judgments, Devon Doctors Ltd should have a policy for staff so they can confidently escalate cases of concern. At the least common sense should have dictated that the member of staff who took the call should have alerted doctors to the breach of a call back to Mrs Morrish.

*'The next call is from a call handler to Mrs Morrish stating she should take Sam to [the Treatment Centre].'*⁸⁸

'Although call handlers do work to guidelines to help them recognise urgent cases and when there is a need

for a 999 ambulance, they should not be making decisions to send an un-triaged patient to a base centre. If in fact they had alerted or escalated the case immediately to the doctors, it is most probable the doctors would have called Mrs Morrish straight away and advised either [to take Sam to] A&E or [call] a 999 ambulance.'

22. The Out-of-Hours Adviser confirmed that the advice given to Mrs Morrish about where to send Sam should have been made by a clinician and 'the guidelines for call handlers were not robust enough to alert a non-clinician to the significance of the change in Sam's symptoms'. She added that Devon Doctors Ltd, in their investigations, have acknowledged these failings and have taken steps to address them in the form of service improvements, and they have apologised to Mr and Mrs Morrish.
23. With regard to staffing levels at Devon Doctors Ltd, the Out-of-Hours Adviser said that although their staffing levels were generally appropriate, they have not:

'[provided] any evidence of the systems for contingency planning ... nor does it appear they put these into action on the night in question. If Devon Doctors Ltd are going to rely on the fact the evening was busy and there were mitigating factors such as adverse weather conditions, then it is reasonable to expect them to have instigated their contingency plan. They do not give any explanation why they did not and it is not clear where this responsibility lies. This is a failing of the National Quality Requirements,

⁸⁷ Devon Doctors Ltd confirmed that, if Mrs Morrish's call to their service at 8.52pm had been logged, the computer system would have flagged that the target time for an assessment had been breached.

⁸⁸ This decision was made by the call handler following discussion with non-clinical staff.

which clearly state “they must have robust contingency policies for those circumstances in which they may be unable to meet unexpected demand”

24. The Out-of-Hours Adviser commented that Devon Doctors Ltd ‘have identified (some) failings in the system and have put in place improvements and safeguards to prevent a similar situation arising’.
25. The Out-of-Hours Adviser said that when Sam arrived the Treatment Centre, he had still not been assessed by clinicians at Devon Doctors Ltd, and there should have been an immediate assessment of clinical priority. It was 17 minutes before staff identified the severity of Sam’s illness. Once a GP had assessed Sam, he was appropriately treated as an emergency and the GP arranged for his transfer to hospital and passed the relevant clinical information to the paediatrician at the Trust. The Out-of-Hours Adviser had no criticisms to make of the GP’s action.

The Paediatric Nurse Adviser

26. The Paediatric Nurse Adviser said that when Sam arrived at hospital, his observations were taken, and he was given a fluid bolus by a nurse (at 11.15pm). The Paediatric Nurse Adviser said that after they had given Sam the fluid bolus, nurses should have repeated his observations and calculated his paediatric early warning score to see whether the fluid bolus had worked. Instead, only two other sets of observations were recorded in A&E (at 11.20pm and 12.20am). These were incomplete, and no corresponding paediatric early warning score was calculated. The Paediatric Nurse Adviser said that in view of the clinical signs that
- Sam had sepsis, intravenous antibiotics should have been given in A&E, but they were not given until 1.30am when Sam was in the high dependency unit. He said:
- ‘antibiotics need to be administered within one hour of identification of severe sepsis, after appropriate cultures have been taken. Early antibiotic therapy and identification of the possible source of infection was critical.’*
27. When Sam arrived in the high dependency unit, he had a paediatric early warning score of four. The Paediatric Nurse Adviser said that, therefore, two hours after Sam arrived at hospital, his condition had still not stabilised. He noted that Sam’s paediatric early warning score remained the same until 2am, when it increased to five. His blood pressure had also dropped, indicating that he was in shock. The Paediatric Nurse Adviser said that because the paediatric team had failed to stabilise Sam’s condition, and had in fact noted it was getting worse, the paediatric team should have spoken to the regional paediatric intensive care centre (in Bristol) sooner than it did. He said that ‘it is recommended that contact should be made early in these situations in order to reduce transfer time and optimise clinical outcome for a child’. He added that for every extra hour a child remains in shock, their mortality rate doubles. He said that if there are further signs of ongoing shock following fluid resuscitation, a child should be intubated and placed on mechanical ventilation,⁸⁹ and treated with inotrope drugs.⁹⁰ If such support is required, the paediatric intensive care unit must be involved early to give advice.

⁸⁹ A machine that helps a person to breathe (or takes full control of their breathing).

⁹⁰ Inotrope drugs alter the force or strength of the heart’s muscular contractions.

28. In summary, the Paediatric Nurse Adviser said that:

‘There was a delay in the administration of intravenous antibiotics to a child with signs and symptoms of sepsis. I also believe that Sam would have stood a much better chance of survival if early consultation with a Paediatric Intensive Care Unit had occurred. Instead, Sam was allowed to decline with interventions primarily focused on fluid resuscitation until he eventually arrested and died ... I believe Sam’s care was compromised with respect to these two issues.’

The Paediatric Intensive Care Unit Adviser

29. The Paediatric Intensive Care Unit Adviser explained that:

‘Children’s intensive care in the UK is organised around a small number of “lead centres” that provide centralised intensive care services for children in a specific geographical region. Critically ill children who present to hospital are first stabilised and then transferred to the lead centre. Specialist paediatric retrieval teams⁹¹ are responsible for transferring patients from the referring hospital to the lead centre. Retrieval teams may be based within a specific paediatric intensive care unit, or may be “stand alone”, serving the needs of more than one paediatric intensive care unit. Stand alone retrieval teams and paediatric intensive care units also have a requirement to provide advice and support to local hospitals in stabilising critically ill children.’

⁹¹ A retrieval team consists of highly skilled clinicians who have specialist training in the transfer of sick children from other hospitals.

30. The Paediatric Intensive Care Adviser explained that the specific criteria for referring a child to a paediatric intensive care unit, or for seeking advice on a child’s management from a paediatric intensive care unit, vary around the UK. However, established good practice is for a child’s condition to be discussed with the paediatric intensive care unit when a senior clinician is concerned that a child is deteriorating and is not responding to treatment. The Paediatric Intensive Care Unit Adviser said that by the time Sam was admitted to the high dependency unit:

‘there was no evidence he had an adequate or sustained response to treatment. The local team (at the Trust) should have requested advice from the local paediatric intensive care unit at that time [1am] or shortly afterwards.’

31. The Paediatric Intensive Care Unit Adviser said that if doctors at the Trust had contacted the paediatric intensive care unit for advice at 1am, the advice they received would probably have been to give Sam aggressive fluid therapy (certainly more than was given) over 10 to 15 minutes, and to assess his response continually. In contrast, Sam was given fluid therapy more slowly and reviewed less frequently. He added that if Sam had not responded to more aggressive fluid therapy, the advice from the paediatric intensive care unit would probably have been for doctors to stabilise him and support his breathing with intubation and ventilation. The paediatric intensive care unit would have advised staff at the Trust on how to safely give anaesthetic to allow intubation, and how to properly ventilate him. The Paediatric Intensive Care Unit Adviser said that the

Trust would have probably been advised to transfer Sam to the paediatric intensive care unit when he was stable.

32. The Paediatric Intensive Care Unit Adviser said that instead of contacting the paediatric intensive care unit at Bristol at 1am, the paediatric registrar contacted them at approximately 3.30am. The unit advised the paediatric registrar to ‘*stabilise Sam and contact [the paediatric intensive care unit] later*’. The Paediatric Intensive Care Unit Adviser said it is not clear what this meant. He said it should have meant that Sam should be intubated, placed on ventilation, and given further fluid therapy and inotropes, and that he should be referred for admission to the paediatric intensive care unit when his condition stabilised.

The Paediatric Consultant Adviser

33. The Paediatric Consultant Adviser said that when Sam was admitted to hospital, he was appropriately assessed and examined, and was given oxygen and a fluid bolus. Signs and symptoms of sepsis were correctly identified, and an appropriate broad-spectrum antibiotic was prescribed in line with the Sepsis Guidelines. He said that on the balance of probabilities, because an X-ray and clinical assessment in hospital showed that Sam had extensive consolidation of his right lung, there would ‘*almost certainly have been some abnormal chest findings on examination at 4.30pm on 22 December when Sam was reviewed by the Second GP*’. The Paediatric Consultant Adviser agreed with the Paediatric Nurse Adviser’s and the Paediatric Intensive Care Unit Adviser’s comments about the inadequacy of Sam’s fluid resuscitation and the delayed contact with the paediatric intensive care unit in Bristol. He said that intravenous antibiotics

should have been started as soon as possible because ‘*poor outcomes are associated with ... delays in administering antibiotics*’. He added that, had Sam been given the prescribed antibiotics immediately (as he should have been), and received more aggressive fluid therapy, and had the paediatric intensive care unit been involved earlier, it was probable that he would have survived, although this was not guaranteed. The Paediatric Consultant Adviser said that by the time Sam was given antibiotics (at 1.30am), he had significantly deteriorated and by that time his chances of surviving were low ‘*even with maximal intensive care*’.

34. The Paediatric Consultant Adviser commented on whether Sam would have survived if he had been admitted to hospital by the Surgery earlier on 22 December. He said, assuming that Sam would have been admitted for a paediatric opinion, he would have been assessed in hospital in line with the Feverish Illness in Children and, in light of his history, had blood tests and a chest X-ray. The Paediatric Consultant Adviser said, on the balance of probabilities, the blood investigations and chest X-ray would have demonstrated significant infection and Sam would have been given broad spectrum antibiotics. If he had been given antibiotics after being referred to hospital by the Second GP at 4.30pm, and received more aggressive fluid therapy, with earlier involvement of the paediatric intensive care unit, ‘*Sam would almost certainly have survived*’.
35. If NHS Direct had told Mrs Morrish to take Sam to hospital, the Paediatric Consultant Adviser said, it was likely he would have been given antibiotics for his infection, had more aggressive fluid therapy, and been seen sooner by the paediatric intensive

care unit, and he would probably have survived. If Devon Doctors Ltd had seen Sam sooner than they had (and referred him to hospital as they eventually did), and Sam had received antibiotics sooner than he did (and had more aggressive fluid therapy and the earlier involvement of the paediatric intensive care unit), it is also probable he would have survived.

36. The Paediatric Consultant Adviser did, however, point out that some children with sepsis can still develop complications and die, even with appropriate antibiotic and supportive treatment.
37. The Paediatric Consultant Adviser also gave advice on the discussions the paediatric consultant had with the coroner’s officer on 23 December. He said that because the paediatric consultant had not known, at the time, about the failure to give Sam antibiotics in a timely manner, it was not inappropriate that he did not discuss it with the coroner before the death certificate was completed.

Responses to our enquiries

38. We made enquiries of the individuals and organisations who assessed and treated Sam.

The Surgery

The First GP

39. The First GP explained that both Sam and Mr Morrish had an appointment to see him on 21 December as they had had ‘*respiratory symptoms*’ for the preceding week (although Sam’s brother and Mrs Morrish attended the appointment as well). He said that Mr and Mrs Morrish told him that Sam’s brother had been unwell with a similar illness but had overcome it without ‘*medical assistance*’. The First GP said that Sam’s parents told him they were

concerned about his high fever, cough, rash and vomiting and ‘*on discussion I got from the history that the rash was fairly new, his fever was very high at times and that the vomiting (although at times random), was after a spell of coughing. He had been unwell for about one week*’.

40. The First GP said he recalled that Sam was ‘*alert and friendly, slightly subdued and allowed me to examine him easily*’. He said that Sam’s rash reduced when gentle pressure was applied. He added that:

‘*at this time I would have assessed his capillary refill time ... although I have not formally documented this, it is my normal practice to assess this and to document if abnormal. I have no reason to believe that I varied from normal practice on this occasion.*’

41. The First GP described how Sam’s colour ‘*was good*’ and his hands ‘*well perfused*’ (had good colour). He listened to Sam’s back and chest. Sam was taking in air equally to both lungs with no obvious ‘*crackles or abnormal noises which go hand in hand with a pneumonia-type infection*’. He added that Sam did not look like he was struggling to breathe, and although his appetite was reduced, he was managing a ‘*good fluid intake*’. The First GP said that although Sam had a flu-like illness, which was a definitive diagnosis, antibiotics would not usually be helpful. However, Christmas was close and if Sam was to develop symptoms suggestive of pneumonia:

‘*I would be able to help him by prescribing a “delayed script” of amoxicillin antibiotic medication. This would have been in accordance with the fact that Sam had had a lower respiratory tract infection in the past. My advice at the time as I recall is that*

if his symptoms were to worsen that Mr and Mrs Morrish could use the antibiotic. During our meeting together on 25 January 2011 [paragraphs 88 to 98], Mr Morrish recalls the advice I gave in connection with the use of antibiotic relating to breathing, dehydration or decreased communication. My normal practice is to recommend starting antibiotics at home if a child's respiratory rate increases and there are signs of respiratory distress

'At that stage I felt clinically reassured that Sam didn't need [to be admitted to hospital] as although he had a fever, rash and a cough he was alert and interacting appropriately. He had normal colour and peripheries. He did not have respiratory distress symptoms. I felt he did not have a lower respiratory tract infection ... on examination. He would have scored amber in the NICE Guidelines: fever for more than 5 days (amber); normal colour of skin, lips and tongue (green) ... respiratory rate and clinical findings in the green criteria; hydration not noted in the amber criteria (capillary refill time less than 3 seconds); no swellings or lumps noted (green)). Such findings would not necessitate same day specialist review.'

42. The First GP acknowledged that he was 'acutely aware of the lack of clinical observation figures in my consultation documentation'. He said that although he did not assess Sam's heart rate formally (the First GP did not explain why he did not do this), he would have assessed Sam's respiratory rate, temperature and whether he was dehydrated, and documented findings if they were abnormal 'as my usual practice'. The First GP added that the Surgery now has a:

'mechanism to make it much easier to remember to document these figures. We also now have facilities to measure the oxygen levels in the Surgery. I recall that in my interview with [the independent investigators] in August 2011 that heart rate recording was the main point of action that I would need to take further clinical assessments of children in the pre school age group presenting with a feverish illness.'

43. He added that:

'I note that Sam's previous medical history included an episode of pneumonia. Taking this into consideration, this did not change my management on the day I saw him. This is due to the fact that a single previous episode in an otherwise healthy child is not a signal of predisposition to future events. I note that the GP Adviser indicates that Mrs Morrish described Sam's cough as "vicious". I do not recall the word "vicious" used to describe Sam's symptoms on the day when I reviewed him or in the subsequent meeting with Mr and Mrs Morrish. Mrs Morrish is documented as saying that at this stage her feeling was that Sam had a nasty cold but was within the range of what she expected from previous experiences. She said that she was waiting for the wheezy sounding chest to arrive.'

44. The First GP also commented on bereavement support for the Morrish family. He said that his role was limited, but 'as a Surgery, it was felt that Mr and Mrs Morrish may not be comfortable with [the Second GP] or me acting as the main clinicians in this respect'. He said that he did have some clinical contact with the family over Christmas, through

Mrs Morrish's mother who had requested medication for her daughter. He also issued prescriptions for antibiotics to treat invasive group A streptococcus. The First GP also told us that the death of a child is extremely uncommon in primary care, and the GPs at the Surgery had had little experience of dealing with bereaved parents. He said that he felt bereavement support could be best provided by the paediatric team at the Trust.

45. The First GP said:

'On 24 December, I expressed my sincere sympathy and shock to Mrs Morrish's mum and asked if there was anything else I could do to help. I asked Mrs Morrish's mother if it would be appropriate to contact Mrs Morrish at this time and she informed me that Mr and Mrs Morrish would approach us "when they're ready". I didn't question or enquire further and made a personal assumption that the family wanted us to remain distant ... It came to light that the assumption I had made and likely communicated to my colleagues was false. I apologised at the time for this misunderstanding. I explained how this misunderstanding had developed.'

46. The First GP explained that the Surgery now has a formal condolence card that can be sent to any bereaved relative where other contact has become difficult or where communication has become otherwise strained. He explained:

'In the intervening years since 21 December 2010, I have often reflected on the role I played in the care of Sam Morrish. I define my role as the clinician who had the first face-to-face review of a young patient

infected with influenza B but also possibly later with invasive group A strep infection. I diagnosed the first infection but did not find any clinical indication of the second. It was the second infection that sadly led to septic shock and Sam's death. I would like to take this opportunity to again express to Mr and Mrs Morrish and their family my heartfelt apology for this.'

47. Following his meeting with the independent investigator, the First GP said, he now understands how the organism that caused Sam's death worked. He said that when he saw Sam, it was likely that organism was present, but Sam was not 'septic' or in 'shock' because his condition had not progressed to that stage. He explained that most symptoms of sepsis or shock would develop eight to 12 hours after infection. The First GP said:

'This shocked state is a late presentation in such an infection. This would have made the diagnosis very difficult to make, even for hospital specialist according to [the independent investigator].'

48. The First GP explained that he has changed how he clinically examines preschool children and now measures their heart rate 'due to the increased sensitivity of a fast heart rate in the absence of fever to a more serious underlying problem [for example] sepsis'. However, he said that even if he had reviewed Sam's heart rate, it might not have changed the outcome of the consultation because 'a fast heart rate in the context of fever is very common'. Nevertheless, the First GP said that the Surgery's new computer system allows GPs to generate 'templates which act as a [memory aid] during clinical examinations

allowing easier input of data'. He said that he was also attending a course in advanced paediatric resuscitation to update his skills (this happened in June 2013), and *'between 2011 and now I have been appraised and Sam's death has been a major discussion in these appraisals. I remain as up to date as possible with the plethora of clinical guidelines which have been published in this intervening period'*. He added:

'Since my consultation with Sam and his family I have become very careful with the use of delayed prescribing of antibiotics. This has been primarily due to the criticism that I did not give specific advice on when to start using them. I feel that the inherent problem with clear communication in the clinically uncertain world of primary care where test results are not available immediately, and in different patients' responses to clinical instructions, would mean that this clarity is difficult to achieve. I feel that the evidence that was available to me at the time of my consultation with Sam supports the general use of antibiotics in this manner though.'

The Second GP

49. Relying on reports previously prepared about his involvement in Sam's care, the Second GP said that Mrs Morrish telephoned the Surgery at 10.45am, spoke to the nurse practitioner at 1.50pm and spoke to him at 2pm. He said that the initial delay in the nurse practitioner calling Mrs Morrish was *'not unusual, particularly given the time of year, the prevalence of viral infections at the time and the snowbound conditions which all contributed to a significant workload for the triage team'*. He added that the details

of Mrs Morrish's concerns (when she called at 10.45am) would have been taken by a receptionist who had no medical training and who was not expected to be able to prioritise calls based on medical need.

50. After speaking to Mrs Morrish, the Second GP said, he decided he needed to see Sam and made an appointment for 4.10pm. He said:

'this was, I felt, an appropriate time [for Sam] to be seen given that the history I obtained suggested that he should certainly be seen that afternoon and considering other factors such as the time it would take Mrs Morrish to bring him to the Surgery given the weather conditions, other patients I still had to contact and patients I had already arranged to see that afternoon.'
51. With regard to the GP Adviser's comment that he should have asked Mrs Morrish about Sam's urine output, the Second GP referred to the independent report (Annex F) that says:

'[The Second GP] did not assess Samuel's urine output. I asked him if he had known Samuel had not passed urine for 6 hours would this have changed his management plan. He would not have referred Samuel to hospital for admission as Samuel's other indicators of hydration reassured him, but he would have asked parents to push oral fluids over a 2-3 hours period to see if Samuel passed urine. If Samuel had not passed urine following this fluid challenge, he would have recommended contacting the out-of-hours doctor.'
52. The Second GP said that as the Surgery was busy, there was a 20-minute delay

before he saw Sam for his consultation. He said that a detailed account of this consultation was recorded in the independent investigation report. The Second GP acknowledged that he did not record Sam's respiratory rate or how he checked whether Sam was dehydrated. However, he said that in line with his standard practice, he would have asked Mrs Morrish about Sam's fluid intake (which he thought was *'plenty'*), examined his mucous membranes⁹² and checked his capillary refill time (which he said was less than two seconds). None of these showed that Sam was dehydrated. He felt that Sam still had a flu-like illness and, because there was no evidence of a secondary bacterial infection, there was no clear indication to give Sam antibiotics.

53. We asked the Surgery to confirm why the Second GP did not check Sam's nappy for urine output. The Surgery told us that:

'In this specific case, a child who has been sipping a lot through the day and who has moist mucous membranes and a normal capillary refill time is not likely to be clinically dehydrated. Therefore, although the [Second GP] did specifically ask if Samuel was weeing ok and the response had been inconclusive because he was wearing a nappy neither he, nor Mrs Morrish remembered to physically check the nappy to answer the question. However, the question was asked in the context of an assessment of hydration and other aspects of [the Second GP's] examination had satisfied him that, at that stage, Samuel was not dehydrated.'

54. The Second GP accepted that he did not document Sam's heart rate, but disagreed that his heart rate should have been checked in accordance with the traffic light system. He added that following the independent investigation, *'I am now aware, however, of the potential importance of tachycardia [fast heart rate] in the absence of pyrexia [fever] and have incorporated this into my standard practice'*. He added:

'With regards to whether Sam had red or amber criteria based on the traffic light system, as documented, towards the end of the consultation Sam was awake and talking with no evidence of confusion or disorientation. His fever had extended for more than 5 days, and the hydration markers that I assessed were within the green criteria. On my assessment, I accept that he had one amber marker – his prolonged fever, which had also been present the day before, and had I assessed urine output, he would have had two. However, his other markers of hydration were normal and he had no red criteria.'

'In response [to the outcomes Mr and Mrs Morrish seek from this investigation – paragraph 10, final report] I have apologised to Mr and Mrs Morrish in person and within the independent review. This apology still stands and I can only reiterate that I am immensely sorry that Sam died and that despite my best efforts, I did not pick up how unwell Sam was.'

'With regard to personal learning points, these are documented in

92 Which include such things as the linings of the mouth, nose, ears, and genital area.

the independent review sections⁹³ and I have acted on all of these and incorporated them into my usual practice.'

The family's allocated GP

55. The family's allocated GP said that she did not hear about Sam's death until after Christmas. She added that at the time she had only just returned to work following surgery, and was not doing home visits. She said that *'this may have contributed to a perceived lack of continuity of care for the family in the aftermath of their bereavement'*. She said that when she was able to visit the family on 17 January, they discussed *'Sam's illness, his care, reactions to bereavement, the physicality of grief and the various options for counselling and support that might be available [for the family]'*. With regard to bereavement support, she added that:

'Unfortunately, in subsequent weeks, I found it difficult to make telephone contact and this meant that a lot of information was passed [to the family] indirectly via email, which was undoubtedly unsatisfactory. My feeling was that this was a rather specialised area of bereavement care and that the hospital was likely to have more specific expertise especially with regard to support for Sam's brother and we did ask [the paediatric consultant] for help in this matter.'

56. The allocated GP said that she tried to telephone the family on 31 January 2011, without success, but was able to speak to Mr Morrish on 21 February about the bereavement services available. By that time, Mr Morrish had agreed to help from the Trust. She said that she passed information about voluntary agencies and a children's hospice to the family (on 8 March), but without direct contact *'it was difficult to keep a sense of momentum and know exactly what was required, but this did not reflect a lack of interest or concern or an unwillingness to provide support'*. The allocated GP said that she talked to Mrs Morrish about a possible referral to the community mental health team, but Mrs Morrish did not want to be referred there because there was no guarantee she would always see the same counsellor. She said they discussed support that the Surgery or Trust could offer (at their respective premises), but Mrs Morrish did not think she *'could face'* visiting these premises. The allocated GP said as none of the options offered was acceptable, she discussed with Mr and Mrs Morrish other sources of support such as Cruse, and she gave the family a copy of a book that which might have been helpful for Sam's brother. She said that she eventually asked a private counsellor to see Mrs Morrish. The allocated GP said that she spoke to Mrs Morrish on 21 July about the progress of her counselling and her reaction to bereavement. She said Mrs Morrish told her that she was still troubled by anxiety and some panic symptoms, and although her sleep was improving, she still woke

early in the morning. The allocated GP said she spoke to the psychologist who had agreed to see Mr and Mrs Morrish on 12 September. The psychologist felt that the sessions were *'drawing to a close'* and that a further five sessions, to take Mrs Morrish past the anniversary of Sam's death, would be sufficient. The Surgery was told on 24 February 2012 that counselling had come to an end.

57. The allocated GP said that:

'I am very sorry if the family felt unsupported or uncared for as we certainly wished to do everything we could to help them. On the other hand we did not wish to be pushy or intrusive and may have been a little too cautious for which I can only apologise.'

The lead GP

58. The lead GP said that he first spoke to Mrs Morrish's mother when she called the Surgery on 23 December asking for sedatives. He was not able to speak directly to Mr and Mrs Morrish because they were visiting the hospital. He said he remembered telling Mrs Morrish's mother that he wished to offer the family support. He said that during the meeting on 25 January, staff were trying to be sensitive and to give the family space. He accepted that:

'in retrospect, the partners made an error of judgement on this occasion which came about from being oversensitive to concerns that we might make the situation worse if we tried to interfere with more offers of help. We have subsequently tried to explain that our lack of direct contact was not because of a lack of care,

but that we hoped that our messages via Sam's grandmother would have encouraged Mr and Mrs Morrish to let us know when they were ready to allow us to help.'

59. The lead GP explained that, during the meeting on 25 January, the Surgery attempted to explain what it knew about Sam's illness, but was conscious that the paediatric consultant *'was better placed to cover the medical aspects ... and who was seeing the Morrishes independently of us'*.
60. The lead GP recognised that in the absence of any direct contact with Mr and Mrs Morrish, the Surgery should have at least sent a note to the family. Like the First GP, he said that the Surgery has developed a card that it will send to bereaved patients when it has not been possible to telephone or visit.
61. The lead GP recognised how important listening skills are in bereavement counselling and that they are frequently used by GPs. He said that the allocated GP had recently undergone *'considerable extracurricular study'* to enable her to become ordained in the Church of England and that *'as partners, we have, over the years, always valued her skills in pastoral care'*. He added that at the meeting on 25 January, the First GP acknowledged that although the Surgery was not expert in dealing with grief, it could find suitable help for the family. The lead GP said that *'difficulty then arose in finding suitable counselling support for [Sam's brother] as well as both parents who had individual needs'*. The allocated GP then drew up a list of organisations that could help. The lead GP said that there had been *'unacceptable delays in trying to sort out suitable counselling for the family and sincere apologies have been expressed'*.

⁹³ The Second GP has reviewed Feverish Illness in Children, and has the traffic light system on the wall of his office. He told us his usual practice now includes assessing urine output in infants and preschool children to assess hydration, and measuring heart rates in all children he sees. The Second GP said he also completed a Royal College of General Practitioners course about upper respiratory tract infections and the feverish child, and the 'spotting the sick child' course run by the Royal College of Paediatrics and Child Health.

62. The lead GP explained that the independent review report concluded that the paediatric consultant had *'assumed the role of lead professional in fulfilling a "duty of care" to the family following Sam's death'* but that there was confusion relating to the provision of bereavement support. The lead GP recognised that information about bereavement support should be readily available, and was aware that the Trust's *'child death folder'* (which details pathway and bereavement information, including leaflets for patients) has been revised. He said that he has asked for a copy of this information to be made available in GP surgeries.

63. The lead GP said that the paediatric consultant was in a *'much better position to explain the medical aspects of this tragedy'*. He added that the GPs had had the opportunity to discuss their role in Sam's care during the independent investigation and to learn from the investigators' expertise. He said:

'We recognise that it was only because of Mr Morrish's persistence that this opportunity arose. We had hoped to have a frank discussion with a medical representative as part of the [independent] investigation, but this had not happened for the first [root cause analysis].'

64. The lead GP explained the process the Surgery has in place for triaging calls made to its service (a process which was in place when Mrs Morrish called at 10.45am on 22 December 2010). He explained that a duty doctor, free from appointments and based in the reception area, is available for all reception staff to discuss calls with if necessary. He said that all reception staff

are trained in basic call handling and are instructed to assess patient needs and triage calls to the appropriate member of staff. The lead GP said that *'without pressing the patient for too much clinical information, they would assess the severity and urgency of the need and whether that patient required the help of a GP, nurse, secretary or manager'*. He said that if the patient needed to see a GP, and their registered GP was not available, the call would be passed to the duty doctor. Depending on the discussion between the duty doctor and the patient, a *'red flag'* might be placed against the call, which would appear on a GP's list of patients to call back. This would allow the more urgent nature of the call to *'stand out'*. Once the GP has reviewed their list of patients, they will decide who needs to be called first. He said that at the time Mrs Morrish called the Surgery, there were a number of other calls with *'cough and cold'* symptoms, and her call did not stand out as one that needed to be prioritised. The lead GP explained that since December 2010, the Surgery's telephone system has changed so that a caller is presented with an option to go directly through to its *'red emergency phone'* (in case of a collapse or emergency) which will always be answered by *'medical, and trained reception staff to ensure that there is no delay in responding'*.⁹⁴

65. The lead GP said that in 2011, a new practice manager was appointed who arranged for a new telephone system to be installed. He said that this was not as a result of what happened in this case, but to allow the Surgery to assess the number of calls it receives at any one time, and to manage the number of call handlers the Surgery needs at the busiest times.

66. The lead GP sent us information the Surgery has given to West Devon Clinical Commissioning Group about actions it has taken since Sam's death. He clarified that the First GP and Second GP have undergone additional training, telephone staff are being trained in how to direct patients through the telephone triage system, and more telephone staff are available during the busy morning period. He said that the Surgery's patient participation group is monitoring the telephone triage process. The lead GP also said that the reception area has been redesigned to be more open plan.

67. The lead GP told Northern, Eastern and Western Devon Clinical Commissioning Group that there is now clear information about what patients can do if their child is unwell in all waiting areas at the Surgery. The notice explains that *'if you, your child or the person for whom you are the carer, is feeling particularly ill or in pain, please inform a member of staff in the reception area. We will do our best to help you'*. With regard to waiting times, the Surgery's touch screen system, which patients use to register that they have arrived for appointments, now shows whether appointments are running on time and how many patients are still waiting to be seen.⁹⁵

NHS Direct

68. NHS Direct agreed with the NHS Direct Adviser's advice. It added that at the time of Mrs Morrish's call to its service, it did have a *'second calls policy'* in place, although it acknowledged that staff needed to be reminded of this policy (and it said that this had been done). NHS Direct said that the issues raised by the NHS

Direct Adviser corresponded with those it identified during its own investigations and that had the *'nurse adviser accurately documented [Mrs Morrish's] responses in the record, advice for more urgent action may have been reached than was actually given'*.

69. NHS Direct said that as part of its own investigation, it asked the nurse adviser to explain her actions. However, it said:

'the nurse adviser was unable to adequately explain to us the reasons for the problems we found with her assessment or documentation. We were also unable to identify any significant external mitigating factors. This along with other concerns about recent performance, led to our referral to the Nursing and Midwifery Council in order for them to consider her fitness to practise.'

70. NHS Direct subsequently clarified that:

'The nurse adviser involved in this incident was not referred to the NMC in 2011 following our internal investigation. The nurse received a period of clinical supervision where she was assessed and was deemed competent to continue her role. However, the nurse adviser was referred to the NMC in January 2013 due to incidents unrelated to the case of Sam Morrish. I believe that the information provided to you about the referral of the nurse to the NMC was ambiguous.'

71. NHS Direct has told us that the nurse adviser no longer works for its service.

⁹⁴ Mr Morrish has told us that at the time, neither he nor his wife knew that Sam's condition was an emergency, so the option of being transferred to a *'red emergency phone'* would not have helped them then.

⁹⁵ The Surgery explained that although this facility was always available, it was not aware of it at the time. After it became aware of the difficulty Mrs Morrish had experienced, *'it discovered this function which has been in operation ever since'*.

72. NHS Direct said:

'Had a better assessment been undertaken with good documentation by the NHS Direct Nurse Adviser, this could have resulted in a shorter call length, advice to seek more urgent medical attention and quicker face to face consultation at A&E. We cannot comment on what might have happened upon reaching A&E but understand the likelihood is that Sam would have been assessed by a consultant earlier than 10.30pm.'

73. We tried to contact the NHS Direct nurse adviser to discuss her assessment of Sam. She did not respond.

Devon Doctors Ltd

74. Devon Doctors Ltd told us that the information they received from the nurse adviser at NHS Direct was based on a nationally accepted algorithm and therefore constituted a clinical assessment. They said that when one of their GPs, who *'was working an extremely busy shift'*, received this information, it was reasonable for him to have prioritised other non-clinically assessed calls over and above a 'routine' call that had already been triaged by NHS Direct. Devon Doctors Ltd said that there was nothing in the information passed to them from NHS Direct to *'identify any significant clinical concern - specifically and importantly no vomiting of blood, increased thirst or lethargy'*.⁹⁶

75. Devon Doctors Ltd accepted that a definitive assessment of Sam's condition should have begun within 60 minutes of receiving the call (so by 7.44pm). However, they said that it is not unreasonable for a small number of calls to be assessed outside these timescales. Devon Doctors Ltd said that the Department of Health understands that it would be unreasonable to expect 100% of all routine calls to be answered in 60 minutes, and that the Quality Requirements are met as long as a service provider meets the targets in 95% of cases.⁹⁷ They said there are situations where, *'despite the provider's best efforts, they will not achieve the Out of Hours targets in 100% of cases (such as where the telephone call made by the GP is not answered)'*. Devon Doctors Ltd told us that clinicians are aware of the targets in the Quality Requirements and will make all reasonable attempts to achieve them.

76. Devon Doctors Ltd confirmed that the GP did not 'lock' Sam's case in the system because the team provide support to each other. They said that 'locking' a call would prevent any other clinician from accessing it and taking responsibility for the case.

77. Devon Doctors Ltd acknowledged that if the GP had been able to make contact with Mrs Morrish, it was highly likely that he would have wanted to assess Sam in person. However, they explained that they could not say for certain whether the GP would have upgraded Sam's case to 'urgent' because it is conjecture to say what Sam's symptoms would have been when he saw a doctor. As they could not

say what Sam's symptoms would have been, they could not say whether the GP would have arranged an ambulance for Sam, for him to be kept at the Treatment Centre for observations, or sent home with antibiotics. Nevertheless, Devon Doctors Ltd accepted that when their staff were made aware (just after 9pm) that Sam had vomited black liquid, an ambulance should have been sent immediately.

78. With regard to their service responsibilities, Devon Doctors Ltd said:

'extensive efforts were made by the service to ensure that we continued to deliver a GP out-of-hours service going into a four day bank holiday weekend with unprecedented adverse weather conditions and a clear spike in respiratory based illness with different strains affecting young children. I can confirm that the service was fully manned with GPs up to our commissioned levels across the whole of Devon that evening, despite the problems caused by the weather and high levels of sickness among GPs and staff. In addition, we have clear and effective systems for managing peak demand and contingency planning for supply side interruptions in service.'

79. Devon Doctors Ltd added that the service at the Treatment Centre (and the rest of Devon) was not failing that evening and the *'GPs concerned were working incredibly hard and there were points at which they were under extreme pressure. However, the service standards at Newton Abbot were within the [Quality Requirements] targets'*. They added that they had *'clear and effective systems for managing peak demand and contingency planning for supply side interruptions in service [lack of availability of staff]'*. They said

that it was not necessary to implement these contingency plans on 22 December because, although very busy, their service was *'fully manned with GPs up to our commissioned service'*.

80. Devon Doctors Ltd accepted that there was a poor call back process (at 8.52pm and 9.08pm), a failure to recognise that Sam arrived at the Treatment Centre without having had a definitive assessment, and a failure to identify a life-threatening condition at 9.08pm. They said that they have accepted these failures, and apologised to Mr and Mrs Morrish, and have made changes to their systems to try to make sure the failings are not repeated.

81. Devon Doctors Ltd also gave further information about their meeting with Mr and Mrs Morrish on 25 May 2011, and in particular, the comment that blood in vomit can be caused by alcohol misuse. Devon Doctors Ltd told us that they would not have been trying to imply that Mr and Mrs Morrish had given their son alcohol, but were trying to get across to the family why some people vomit blood, and that in adults, alcohol can be a cause.

82. In a further response to our enquiries, Devon Doctors Ltd clarified their policy for dealing with unanswered calls to patients. They stated that local clinicians can prioritise calls to patients that go unanswered, and can decide which actions they need to take. These include leaving the call open on the computer system to prioritise *'clinical work which has not received a clinical assessment'*; make repeat calls themselves; or request another member of staff to take further actions (such as checking to see that they have the correct contact telephone number). Devon Doctors Ltd said that, based on the information available to clinicians up until

⁹⁶ The Out-of-hour Adviser has explained that the phrase *'vomiting brown lumps'* would not necessarily indicate that a patient was vomiting blood.

⁹⁷ Devon Doctors Ltd have shown us the statistics (for the evening of 22 December 2010) for the percentage of calls that had a definitive assessment that started within 60 minutes: between 6pm and 7pm – 100%, between 7pm and 8pm – 92%, between 8pm and 9pm – 78%, between 9pm and 10pm – 100%, and between 10pm and 11pm – 100%.

9.08pm (when Sam vomited black liquid), it was reasonable for the clinicians to give priority to calls that had not been clinically assessed.

83. With regard to clinicians not beginning a definitive assessment of Sam's condition within 60 minutes, Devon Doctors Ltd said the Out-of-Hours GP Adviser criticised them for:

'not having a policy in place for staff to escalate concern, for not triggering an escalation (at 8.52pm) and not informing the GPs by instant messaging (at 8.52pm) that they had breached the relevant [Quality Requirements target] for this call. We would like to clarify that there was no apparent concern either in words or voice expressed by Mrs Morrish to the call handler at 8.52pm, the call was made in order to state she believed she may have missed a call from a GP. Whilst it is accepted that the call operator failed to document this contact on the software system, she did ring the base and inform them of the call back due to Mrs Morrish having missed the call from the doctor at around 7.30pm. The call operator does point out that the call was ... waiting for a call back. With reference to the notification of a breach of the [Quality Requirements] it is also relevant for the Out of Hours GP Adviser to know that the GPs and staff know the [Quality Requirements] status of every call – as they are, due to software configuration, colour coded on their work screens.'

84. Devon Doctors Ltd told us that they *'had and have robust contingency plans'*. They said that their business resilience plan was implemented before 22 December and *'as a result all bases were fully operational, all staff and GPs were at work and all*

resources such as 4x4 vehicles, larger drug stocks and additional equipment were in place'. They said that demand escalation is:

'where additional clinical resource is sought as well as demand prioritisation measures applied to deal with a surge in demand. The key triggers for applying demand escalation are failures in the relevant NQRs. The reason our demand escalation plans were not implemented is that they were not triggered, and the reason they were not triggered on 22 December is that Devon Doctors Ltd continued to meet its NQR standards ... It is also important to stress that Devon Doctors Ltd do not and have not used the weather conditions or that fact that the evening was busy with a particular profile of urgent cases in the Newton Abbot area as a mitigating factor in this case. It was used as relevant context but it does not excuse our service for any service failings identified.'

85. Devon Doctors Ltd explained the role of support staff in providing help to clinicians:

'Role of the Control Centre

'Whilst the clinical responsibility for the call sits with the clinicians at the receiving treatment centre it is the responsibility of the Control Centre to support the treatment centres operationally to ensure that all calls are dealt with promptly and safely.

'Dispatchers

'Dispatchers should be constantly reviewing outstanding calls and be proactive in highlighting any calls where there is potential for harm to a patient.

'If there is failed communication or an outstanding call where a patient has failed to attend for an extended period, the call should be brought to the attention of the Duty Team/Shift Manager.

'Team/Shift Manager

'As part of the Team/Shift Manager role, staff should be linking with the dispatchers/ reviewing the screen in order to support staff and offer guidance based on the criteria above to ensure that patient safety is not compromised.

'Where there is a cause for concern, the Duty Team/Shift Manager should link with the Treatment Centre direct to discuss and ensure that all steps have or are taking place to safeguard the patient and where appropriate escalate and seek advice from a Senior Manager or Medical Director.'

The Trust

86. The Trust said that the paediatric registrar who assessed Sam was recruited with the necessary competencies and training required for his position and had seven years of paediatric experience. The Trust said that the paediatric registrar contacted the paediatric consultant, told him about Sam's condition and his proposed treatment plan, and the paediatric consultant agreed with the plan (and also advised him to conduct X-rays, and to request opinions from a surgeon and the intensive treatment unit). The Trust confirmed that the paediatric consultant arrived at the hospital within 10 minutes of the paediatric registrar contacting him.

(The paediatric consultant subsequently left hospital before Sam was transferred to the high dependency unit, but returned at about 4am.)

87. We asked the Trust about the discrepancy in the explanations offered for the delay in giving Sam antibiotics. (The root cause analysis report says it was due to A&E nurses lacking experience while the paediatric consultant said it was because staff prioritised getting Sam transferred to the high dependency unit.) The Trust said that it could add no more to what has already been documented in the independent investigation (Annex F). The Trust said that it was not sure whether the explanation in the root cause analysis report came from the PCT, or if it came from someone at the Trust. It said that if it was the latter, it could not confirm who gave this information.
88. With regard to why it took so long for Sam to receive antibiotics, the Trust told us that Sam's prescription for antibiotics was written at about 11pm on 22 December. Sam subsequently received medical input from a number of doctors and received fluid boluses and oxygen, and nurses observed Sam during this period. The Trust said that when the A&E nurse was informed that antibiotics had been prescribed for Sam, he had been scheduled for transfer to the high dependency unit, and staff on that unit were told about the need to administer antibiotics on his arrival. However, the intensive care team arrived to review Sam and his X-rays, so his transfer to the high dependency unit was delayed. The Trust confirmed that its current practice is to administer fluids, oxygen and antibiotics within one hour of sepsis being identified.

89. After meeting Mr and Mrs Morrish on 27 January 2014, the Trust was able to give the family more information about why there was a delay in giving Sam antibiotics. It said that Sam was appropriately assessed when he arrived in A&E. However, whilst doctors correctly prescribed Sam intravenous antibiotics, this was not written in the correct section of his medical records. It explained that as there was insufficient communication between doctors and nurses, the note of this prescription was not discovered until a nurse saw the entry in the records at about 12pm. Staff decided that as it would take time to get intravenous drugs for administration, the priority should be to transfer Sam to the high dependency unit. The Trust accepted that this was the wrong decision, and that Sam should have received antibiotics within an hour of sepsis being identified.

90. With regard to its own investigation into Sam's death, the Trust told us that whilst it could not say exactly when the investigation was completed, its investigation report would have been used in the root cause analysis meeting (in April) and at a child death review meeting (in May). The Trust also told us that it did not take a statement from the paediatric consultant during its internal investigation because it considered that it had enough information about his involvement based on the medical records and the minutes of his meeting with Mr and Mrs Morrish on 17 January 2011.

91. Following meetings with Mr and Mrs Morrish in January 2014, the Trust wrote to us highlighting concerns it had about our provisional findings. It said:

- 'When Sam collapsed, his arrest was felt to be principally a hypoxic arrest rather than purely due to

septic shock. The attending team were able to establish a cardiac output, but were unable to correct the hypoxia despite intubation and ventilation. We think this hypoxia was due to a combination of pulmonary necrosis, haemorrhage and by then well-established disseminated intravascular coagulation. (The sequential blood tests taken during Sam's few hours in the hospital demonstrated that he was developing disseminated intravascular coagulation, with a prolongation of his coagulation blood tests).

- 'The post mortem findings indicated that both lungs were oedematous and haemorrhagic, and the major airways contained red mucoid material.
- 'Histology from the lungs showed evidence of extensive haemorrhage and necrosis of the lung.
- 'There was no histological evidence of acute tubular necrosis on the histology of the kidneys which one might have expected in a patient dying from septic shock.'

The Trust explained that 'It would seem probable that the reasons for Sam's death were hypoxia due to extensive pulmonary haemorrhage, due to invasive streptococcal infection secondary to influenza B'. The Trust accepted that there was an unacceptable delay in giving Sam antibiotics and contacting the paediatric intensive care unit, and inadequate fluid resuscitation. It also accepted the failings related to its investigation and bereavement support. However, it felt that 'in the light of the above, Sam's survival was improbable rather than probable'.

The paediatric consultant

92. The paediatric consultant told us that the paediatric registrar was a locum⁹⁸ and it was his first shift on call, although he had been at the hospital for a few days. He said the paediatric registrar came with good credentials, and there had been no question about his competence. The paediatric consultant explained that on the night Sam was admitted to hospital, he and the registrar assessed him in A&E, along with the intensive treatment unit doctor. Between them, they decided what Sam's management plan would be, and when the plan was in place, the paediatric consultant went home. The paediatric consultant explained that it was not just the registrar's duty to contact him about Sam's condition, but that nurses had the authority to contact him as well. Indeed, he recalls that the sister at the time asked the registrar to call him because Sam had deteriorated. He discussed the case with the registrar and decided to return to hospital (about a 10 to 15 minute journey), but by the time he arrived, Sam had 'collapsed'. He said that while he was not at the hospital, he felt adequately involved in Sam's care and the doctors and nurses knew they could contact him and he would return. He drew attention to the fact that there were a lot of experienced people involved in organising Sam's care (including registrars, surgical consultants and intensive treatment unit specialists).

93. The paediatric consultant said the delay in giving Sam antibiotics was nothing to do with nurses being inexperienced (as is noted in the final version of the root cause analysis investigation report). He

said that by the time nurses realised that Sam had not been given antibiotics, he was being prepared for transfer to the high dependency unit. Rather than delay his transfer, nurses agreed with doctors that Sam would be given the medication when he arrived in the high dependency unit. The paediatric consultant accepted that this was the wrong decision and that administering antibiotics should have taken priority over transferring Sam.

94. The paediatric consultant acknowledged that he might⁹⁹ have told Mr Morrish there had been a 90-minute delay in giving antibiotics. He said he had been trying to convey to Mr Morrish that the administration of Sam's antibiotics had taken longer than it should, and he had simply misjudged the timings. He was not trying to deliberately mislead Mr Morrish.

95. The paediatric consultant also told us about his involvement with the family after Sam's death. He said that he had been in contact with the family the moment Sam died, but that he felt the main responsibility for organising counselling fell to the Surgery. In his view, the main shortcoming relating to bereavement care was the delay in finding support for Sam's brother. He said that while there are support mechanisms for bereaved parents, there are very few for bereaved siblings. The paediatric consultant told us that, after speaking to the public health nurse team involved in a child death review panel, after the meeting in May 2011, they told him they could have provided support for the family, including Sam's brother. The issue was that support from the nurses was only usually offered to families of

⁹⁸ The paediatric registrar confirmed that he was not a locum and was employed by the Trust as a speciality doctor in paediatrics. He said that on the night Sam arrived in A&E, it was his third on-call shift and his third night shift.

⁹⁹ Mr Morrish said that there is no doubt that the paediatric consultant told him that there was a 90-minute delay.

children who had died outside hospital (for example, when there had been a cot death at home). It was only when the child death review process started that he realised that nurses were willing to offer this support to the Morrish family. He acknowledged that the family, including Sam's brother, would have found this support very useful. He added that it is very rare for children to die of a serious infection, and he believed that at the Trust, such deaths occurred perhaps every two or three years. Therefore, there was no formal process in place to support families of children who died in these circumstances, and it can be very difficult to find support.

96. The paediatric consultant told us that Sam died from a rare condition. Not only did he have flu, but he had another bacterium on top of that. He said that he spoke to a bacteriologist at the time who told him that even if there had been no delay giving Sam the antibiotics he was prescribed in hospital, it was unlikely he would have survived.¹⁰⁰
97. The paediatric consultant explained why he did not attend the root cause analysis meeting on 28 June 2011. He said his decision not to attend had nothing to do with whether it was a non-working day for him (although he agreed that he might not have been scheduled to work that day).¹⁰¹ He explained that he had met Mr and Mrs Morrish a number of times (including immediately after Sam had died, and then again a few weeks later) to explain what had happened to their son. He said he did not feel it was appropriate for him to be involved in the root cause analysis meeting in case there were criticisms of his clinical

competence. He said that he did not believe the meeting would be independent if he was there trying to defend his actions, and the Trust sent another consultant instead. He stressed that he had wanted the meeting to be impartial.

98. The paediatric consultant confirmed that he was responsible for Sam's care and overall clinical management. He said that during Sam's admission, he needed to be in a place where any decisions could easily be referred to him. It would not be normal, or possible, for a paediatric consultant to stand by the side of a single patient's bed as he would probably have 40 to 50 other patients to see. He added that it would also be very rare for an on-call consultant to be at the hospital throughout the night, and whilst this might happen in some hospitals, it would not be the norm. The paediatric consultant said that, regardless of whether he was at home or at hospital, he would still be expected to be involved in a patient's overall clinical management. He added that from receiving a call at home about a patient, it would take 15 minutes (at most) to arrive at the hospital. He said that this can be quicker than a consultant who is on site but at the other side of a hospital.
99. With regard to the decision to transfer Sam to the high dependency unit rather than the Trust's intensive care unit, the paediatric consultant said that the intensive care unit is not a child-friendly environment. There are a lot of unconscious people in the unit, mainly adults, with lots of wires coming out of them. The high dependency unit is a more child-friendly place and is part of the

paediatric ward – it is less threatening. The paediatric consultant said that at the time the decision was made to send Sam to the high dependency unit, he was alert and reacting to voice. He said the doctors' and nurses' view (that it would be best for Sam to be in a more child-friendly place) was correct.

100. The paediatric consultant accepted that he probably talked to Mr and Mrs Morrish about no longer having to work night shifts, as he was retiring a couple of weeks later and would only be working in outpatient clinics. He said that he did not mean to be insensitive, and apologised profusely if this was how the family had taken his comments.
101. The paediatric consultant explained that if a patient dies within 24 hours of being admitted to hospital, their death must be referred to the coroner. He acknowledged that he did not read Sam's medical records before he spoke to the coroner because at the time, he was involved in his care and felt he knew what had happened. The paediatric consultant said that even if he had read Sam's medical records, unless he knew what he was looking for, it was doubtful whether he would have identified the delay in giving Sam antibiotics. He explained that the information relating to when drugs were prescribed and administered, given the context of the amount of medical input Sam had had, would not have stood out. The paediatric consultant said that, in hindsight, he probably should have read Sam's medical records before speaking to the coroner. However, he said that this is not something that paediatricians would routinely do.

Further clinical advice

102. We obtained further clinical advice on the responses to our enquiries.

The GP Adviser

103. The GP Adviser commented on the Surgery's responses to our enquiries. With regard to how the Surgery handled Mrs Morrish's telephone call on the morning of 22 December, the GP Adviser said that it is not satisfactory for a receptionist to put calls onto a generic list without knowing how long it might be before a GP will call the patient. The Surgery should provide guidance to enable receptionists to assess the urgency of a call (for example, chest pains or a possible stroke). This is not the same as clinical triage, which is a task for the doctors and nurses. For a sick child, the receptionist should have had simple guidelines to ask the parent how ill they believe their child is and how long they feel safe to wait until the doctor or nurse phones back.
104. The GP Adviser said that whilst Sam might not have had any of the red features of the Feverish Illness in Children traffic light system, he certainly had a number of amber features. The options available to doctors when a child fits the amber criteria include either sending them home with 'safety net' information, or referring them to a paediatric specialist.
105. The GP Adviser said that the Second GP did not conduct an adequate assessment. He did not take Sam's heart rate and temperature. And, despite it being recorded that Mrs Morrish had told the nurse practitioner that Sam had been 'sleeping a lot', he failed to ask further questions about this issue. Importantly, the Second GP did not check Sam's nappy. We know that Sam had been in his nappy

¹⁰⁰ This view was supported by the Trust after we shared a copy of the draft report with it. The Trust subsequently agreed with our findings after we sent a copy of the Infectious Diseases Consultant Adviser's advice to it.

¹⁰¹ Mr and Mrs Morrish said that what the paediatric consultant told us was wrong.

for several hours, and it would have been dry if the Second GP had checked it. It was not a case that Sam simply had reduced urinary output, he had had no urinary output for several hours. Furthermore, Mrs Morrish clearly describes how much worse Sam's condition had become; she described how he was falling asleep in the waiting area of the Surgery. Whilst the GP Adviser acknowledged how difficult it can be for a GP to recognise a seriously ill child, rather than one with flu-like illness, the Second GP did not obtain enough evidence – including taking account of Mrs Morrish's concerns about how much worse Sam was – to be in a position to adequately manage his condition. She explained that the Second GP could not have made a definitive diagnosis of Sam's condition because he had not conducted an adequate assessment in order to reach such a diagnosis. The GP Adviser said that if the Second GP had conducted an adequate assessment, including taking proper account of Mrs Morrish's concerns, it would have been good practice to have referred Sam to hospital immediately. She added that the Second GP's actions falsely reassured Mrs Morrish about her son's condition.¹⁰²

The NHS Direct Adviser

- 106. Mr and Mrs Morrish have told us that they consider that the NHS Direct algorithm used to assess their son was 'faulty', and was subsequently changed in the period after Sam died.
- 107. The NHS Direct Adviser reviewed the algorithm the NHS Direct nurse adviser used to assess Sam. He said that had the nurse adviser answered 'yes' to the

question about whether Sam had bile-stained vomit, or had vomited blood or coffee ground material (as she should have), the nurse adviser would have been prompted to tell Mrs Morrish to take Sam to A&E as soon as possible. The NHS Direct Adviser noted that the algorithm was subsequently changed. If an answer of 'yes' was now recorded to the same question about vomiting, the algorithm would prompt a NHS Direct adviser to make a 999 call and arrange for an ambulance to be sent to the patient's home.

- 108. The NHS Direct Adviser said that since the NHS Direct investigation, the urgency of the algorithm has increased. He said that:

'this is not to say that the [previous] algorithm was "faulty", but that callers now have their child's emergency care simplified by transferring the caller to ambulance control for a 999 response. This saves the caller having to arrange transport at short notice and taking their child to A&E.'

The Out-of-Hours Adviser

- 109. The Out-of-Hours Adviser said that the system she has described for handling unanswered calls is based on her wide experience and research into other providers. She said that Devon Doctors Ltd put the onus on the clinicians to decide the action to take regarding managing calls and service levels. She said that this was unreasonable, especially given the demands on clinicians in busy periods. The Out-of-Hours Adviser said that Devon Doctors Ltd were busy on 22 December 2010, and:

'expecting clinicians to review unanswered calls and then decide on what action to take while balancing clinical priorities of other calls and patients already present seems a wholly unacceptable system, and in this case, led to Sam not being assessed for a considerable period of time.'

- 110. The Out-of-Hours Adviser said that doctors are responsible for calling patients to discuss their condition. She added that Devon Doctors Ltd also highlighted the actions various support staff could take to help prioritise who doctors should call back. She said that:

'it seems none of these actions were attempted on the night in question. The guidance also states that the control centre, dispatchers and shift managers should all be constantly reviewing outstanding calls and the control centre should support the treatment centres operationally to ensure that all calls are dealt with promptly. It would seem that Devon Doctors Ltd would like to lay responsibility for managing unanswered calls on their doctors, however, it does have a policy which clearly highlights the role their administrative staff should take, and it is clear that on the night in question despite the fact the call to Mrs Morrish was on the system, and would have been colour coded as having breached the time allowed, no one did anything to highlight this to the clinicians who, by Devon Doctors Ltd's own admission, were under pressure due to high demand.'
- 111. The Out-of-Hours Adviser said that when Mrs Morrish called Devon Doctors Ltd at 8.52pm, although she did not highlight any new symptoms, *'the fact is a patient's*

mother had to ring to alert Devon Doctors Ltd to the fact she missed the first call and had not received another after a prolonged period of time'. She said that whilst the call handler alerted the Treatment Centre that Mrs Morrish had called, there is no evidence that the clinicians were informed. The Out-of-Hours Adviser said that Devon Doctors Ltd should have had an escalation policy in place to alert clinicians about calls breaching the time allowed by the Quality Requirements.

- 112. Mr and Mrs Morrish asked whether, when Devon Doctors Ltd first received information from NHS Direct that stated that their son was 'vomiting brown lumps', doctors should have questioned whether the call had been correctly assessed as 'routine'. The Out-of-Hours Adviser said that the description of 'vomiting brown lumps' could be from any number of causes (diet, discoloured sputum). On the balance of probabilities, Devon Doctors Ltd would have felt reassured that NHS Direct had properly discussed the case with Mrs Morrish, and had *'felt comfortable with triaging the case as routine'*. She added that *'I do not think it is reasonable to expect them to have upgraded the call on the basis that they realised NHS Direct got it wrong'*.
- 113. The Out-of-Hours Adviser said that whilst it was understandable for Devon Doctors Ltd to prioritise other calls that had not been clinically triaged ahead of Sam's, it does not explain why they did not put further resources in place to deal with unanswered calls. She said that on 22 December, Devon Doctors Ltd were fully staffed, and overall for that day, they met the Quality Requirements target for the definitive assessment of routine patients.

¹⁰² Mr Morrish told us that his wife was not reassured following the consultation with the Second GP, but by him telling his wife that if the Second GP had sent Sam home, then his 'condition could not be so bad'.

She also confirmed that Devon Doctors Ltd's contingency plan (paragraph 300) was robust, and they had anticipated high demand over the winter holiday period. Nevertheless, on the evening of 22 December, Devon Doctors Ltd *'failed to act on the fact calls were breaching significantly and the clinicians were obviously struggling and this should have prompted some action'*.

The Paediatric Consultant Adviser

114. The Paediatric Consultant Adviser provided further advice about the treatment Sam received at the Trust, and about the actions of doctors. He said that it was:

'essential that Sam was cared for in a clinical area which had the appropriate level of nursing and medical staff to ensure that he was adequately monitored and also ensure that changes in treatment could be implemented immediately. I would accept the paediatric consultant's view that initially it was appropriate to send Sam to [the high dependency unit] because he was awake and responding, and at that stage did not require ventilation. However, as has been detailed by the Paediatric Intensive Care Unit Adviser (paragraph 246), Sam's clinical response to the administration of fluid boluses was not sustained and he required further fluid resuscitation. His clinical condition should have been discussed with the paediatric intensive care unit at Bristol at 1am. Had this discussion taken place, the likely advice would have involved the administration of further fluid boluses and supporting Sam's breathing, which would have required transfer to ICU.'

115. The Paediatric Consultant Adviser noted that the paediatric registrar thought Sam should be in the intensive care unit. He said that it was correct for staff to express concern about giving repeat fluid boluses, because too much fluid can affect a patient's ability to breathe. Sam needed further fluid resuscitation, and should have been sent to the intensive care unit so that his breathing could be supported.

116. The Paediatric Consultant Adviser explained that when Sam was admitted to hospital, although he was clinically dehydrated, his blood test results were *'normal and therefore there was no evidence of kidney impairment on admission to hospital'*. He added that:

'Sam had evidence of both clinical dehydration and shock on admission to hospital. Both of these required more aggressive fluid therapy than was administered. Sam was not in established kidney failure on admission, but due to shock, sepsis and inadequate fluid resuscitation, his kidneys would have been failing and subsequent blood investigations would have demonstrated evidence of renal impairment. His urine output should have been monitored more accurately during his admission to ... avoid renal impairment.'

117. The Paediatric Consultant Adviser noted that Sam was given salbutamol, ranitidine and paracetamol while in hospital. He explained that these were appropriate drugs given Sam's condition, and were administered in the correct dosages.
118. The Paediatric Consultant Adviser commented on the paediatric consultant's decision not to remain at the hospital during Sam's admission. He said that:

'Not uncommonly, on-call consultants will phone from home for an update on unwell patients. Additionally, many consultants would proactively request that the junior medical staff (or nursing staff) phone at a specific time for a clinical update, or would request a phone call if a child is deteriorating or not responding to treatment. This safety netting does not appear to have happened in Sam's case.'

'If the paediatric consultant felt that Sam was clinically stable, then it was not inappropriate for him to have gone home, given that he could be back in hospital in a short period of time. However, given the severity of Sam's illness, I am surprised that safety netting as described above was not in place.'

119. The Paediatric Consultant Adviser explained that there is a statutory list of circumstances in which a doctor has a duty to inform the coroner about a death (footnote 45 – this includes if the death occurs within 24 hours of admission to hospital). The Paediatric Consultant Adviser said that the paediatric consultant *'had a duty, because discussing Sam's death with the coroner, to review the clinical records to determine whether the coroner should be made aware of any aspects of Sam's care'*. He said that:

'it would have been good practice for the paediatric consultant to have read Sam's medical records before discussing the case with the coroner's office when it opened later that morning. If the paediatric consultant had been aware of the delay in giving Sam antibiotics, and mentioned this to the coroner, then it might have

led to the coroner holding an inquest into Sam's death. However, given the amount of information in the medical records, I could not say that even if the consultant had read them before speaking to the coroner's office, he would have picked up on the delay. Given the above, I can understand how the delay was overlooked.'

120. The Paediatric Consultant Adviser added that:

'it is common practice to notify the coroner of a death as soon as possible. Delaying the notification leads to delays in involvement of police, delays the registration of the death and delays the release of the body – all adding to the distress of the bereaved.'

The Infectious Diseases Consultant Adviser

121. We sought advice from an Infectious Diseases Consultant (the Infectious Diseases Consultant Adviser) on the Trust's comments. She explained that when Sam first arrived at hospital, he had clear signs of being unwell, as both his heart rate and breathing rate were higher than they should have been. She said that Sam had clinical features of early shock (pale skin colour, raised heart rate, raised capillary refill time and reduced urine output). The Infectious Diseases Consultant Adviser also said that Sam had a blanching rash, which she said was very likely a toxin-mediated rash.

122. The Infectious Diseases Consultant Adviser said that the blood gases taken at 11.04pm confirmed that Sam's circulation was compromised (he was in shock): his lactate levels were raised. She said that although

Sam's rate of breathing was increased, his oxygen saturation levels were still quite high at 92%, and the partial pressure of carbon dioxide in his blood was normal. Therefore, she said that *'both clinically and as evidenced by the blood gas he had compensated shock'*.¹⁰³ She added that Sam's C-reactive protein levels, and a white cell count that was not raised, indicated that he had a significant bacterial infection. Therefore, by approximately 11.30pm, doctors should have been aware that:

'Sam had a serious illness ... [but] he did not have any irreversible process present. The clinical picture at this stage did not indicate a child who was inevitably going to die, however immediate antibiotic therapy, fluid therapy and respiratory support with regular observations, were indicated. Discussion with the regional paediatric intensive care unit was indicated to discuss the serious nature of Sam's condition and management strategies.'

123. The Infectious Diseases Consultant Adviser explained that Sam should have had antibiotics by 11pm at the latest. The delay in giving him antibiotics allowed the infection to develop and to replicate in his blood stream; this allowed Sam's shock to progress (as evidenced by the deteriorating blood gases at 1.39am) and the development of disseminated intravascular coagulation.¹⁰⁴ The Infectious Diseases Consultant Adviser said that Sam also received inadequate fluid therapy, and he also did not receive the necessary

respiratory support. She said that Sam's respiratory failure was reflected in the increasing amounts of oxygen he needed to maintain his oxygen saturation levels; and that at 1.39am, his blood gas analysis showed a rising pCO₂ (the amount of carbon dioxide in the blood) level, despite an increased rate of breathing, which would usually have reduced the pCO₂ levels.

124. By 12.20am, there were clear signs that Sam was deteriorating (fast heart rate, high capillary refill time despite being given fluids), and doctors should have again sought advice from the regional paediatric intensive care unit, who would *'likely have given advice on the following aspects of care'*:
- *'Circulatory failure: aggressive fluid therapy, intensive monitoring, monitoring of urine output, a further blood gas analysis to assess the response of fluids. Escalation to intubation and ventilation with evidence of fluid resistant shock and commencement of inotrope therapy.'*
 - *'Respiratory support: assisted ventilation is likely to have been requested by 1am at the latest as Sam had signs of respiratory failure – very high respiratory rate, climbing pCO₂, and increasing oxygen requirements.'*
 - *'Antibiotic therapy: I consider it likely that had the paediatric intensive care unit been consulted on this*

case soon after admission; that they would have ensured that antibiotic therapy was started as a matter of urgency; and also widened the antibiotic cover to include other antibiotics that penetrate deep seated infections and treated the toxin release from iGAS. Furthermore, given the blanching rash and developing shock picture, consideration as to the early use of immunoglobulin to treat possible toxic shock syndrome may have been made.'

- *'Other treatments: in the face of the mildly deranged clotting (Sam's blood was not clotting as it should have been) and [vomiting blood] in the picture of serious infection, consideration of the use of fresh frozen plasma¹⁰⁵ would have been made.'*

125. In summary, the Infectious Diseases Consultant Adviser said that Sam was admitted looking very unwell. The Trust's failure to treat Sam's serious infection and escalate his care over the next five hours led to a cardiac arrest. *'Cardiac arrests [caused by] hypoxia (lack of oxygen in the blood) are the result of a period of decompensation. It is my opinion that after admission, Sam was allowed to decompensate and this led to his death'*. She added:

'Had antibiotics been given at 1.30am and admission to a paediatric intensive care unit taken place at that moment (i.e. there was a paediatric intensive care unit in the hospital), I consider that on the balance of probabilities Sam would have survived. However,

as he was in a district general hospital, it is likely that they would have been slower to get him intubated and start inotropes and his chances of survival therefore would have been reduced. I think it unlikely he would have survived.'

'If Sam had received antibiotics at 11pm and been referred to paediatric intensive care unit, it is my opinion that he would have survived. However, antibiotics alone would most likely not have been enough, in severe pneumonia's such as this antibiotics often do not work very fast. In the first instance, antibiotics prevent the condition worsening, prior to an improvement being seen. I consider it very likely that he would have required ventilation to assist his cardiovascular and respiratory systems whilst the antibiotics treated the infection. At 11am, Sam did not have respiratory failure and the severe pneumonia was restricted to the right lung. With assisted ventilation, I do not think he would have suffered hypoxic arrest.'

'Broad spectrum antibiotic cover would have had an immediate effect on the bacteraemia and the progression of shock. Together with optimal fluid therapy, stabilisation or early reversal of shock would have improved his prognosis considerably ... for every hour shock is present, the risk of death is doubled.'

'Had Sam been referred [to hospital] at any time after he was seen by the Second GP at the Surgery, it is my opinion that with optimal management he would have survived.'

¹⁰³ There are three stages of shock: compensated, decompensated, and irreversible. In compensated shock, a number of bodily systems are activated to restore blood flow. This results in a number of changes to a patient's physiological observations, including a faster heartbeat. The patient in this stage of shock has very few symptoms, and treatment can completely halt any progression.

¹⁰⁴ A condition in which blood clots form throughout the body's small blood vessels, reducing or blocking the blood flow, which can damage the body's organs. The increased clotting uses up platelets and clotting factors in the blood and this can result in internal and external bleeding.

¹⁰⁵ Can be used for patients with acute disseminated intravascular coagulation in the presence of bleeding and abnormal coagulation.

Annex E: The PCT’s final RCA report

Executive Summary

Summary of Incident:

A 3yr 8mth old boy attended his GP Surgery on 21st and 22nd December 2010 with what was thought to be viral illness amidst an epidemic of “Swine ‘flu” and during a period of severe freezing weather. After showing signs of physical deterioration during the 22nd Dec. he was admitted to Torbay Hospital Accident & Emergency Dept. at 22:28 as a high priority emergency that evening, having previously contacted NHS Direct and Devon Doctors Ltd GP On-Call Service and attending Newton Abbot Treatment Centre. Despite diagnosing and attempting to treat a Streptococcus Group. A septicaemia complicating an Influenza B infection he deteriorated rapidly and died in the hospital at 05:05 on 23rd December.

Incident Date: 23rd December 2010

Incident Type: Child death

Healthcare Specialty: Multiagency: General Practice, NHS Direct, Devon Doctors Ltd Out of Hours GP Service (Devon Doctors), Minor Injury Unit (MIU) Devon Provider Services (DPS), SWAST (South Western Ambulance Service Trust), South Devon NHS Foundation Trust (SDHT) (secondary care)

Actual effect on patient and / or service: Child Death

Actual severity of incident: Child Death

Level of investigation conducted

Comprehensive — Level 2 — contributing to the Child Death Review Process

Involvement and support of the patient and/or relatives

S’s mother and father are fully aware of the Root Cause Analysis and have two key points of contact within the Cricketfield GP practice (the lead GP), SDHT (the paediatric consultant) Support was provided at the beginning of the process by a friend, who is an employee of NHS Devon.

S’s mother and father also provided a narrative of S’s illness and their experiences during this time. S’s parents will receive a copy of the report and an opportunity to discuss it through with the lead GP and the chair of RCA. Ongoing bereavement support is being provided by SDHT.

S’s father has since been in contact with the chair of the RCA and arrangements regarding feedback of the RCA are being made directly with S’s father

Detection of the incident

S’s death was reported as a Serious Incident Requiring Investigation to NHS Devon by the health visitor team caring for him as and by SDHT to Torbay Care Trust.

All child deaths are also subject to the multi-agency Child Death Review Process and review by the Child Death Local Overview Panel Investigations are co-coordinated by the Child Death Rapid Response Team if the death occurs in the community or soon after arrival in an A&E department, or if there are concerns regarding the manner of the child’s death. The rapid response team will co-ordinate the local case review meeting, which will form recommendations to the Local Overview Panel regarding cause of death.

If a child dies within a hospital and there are no concerns the paediatrician has a requirement to hold a multi-disciplinary local case review as per the Child Death Overview Process, which

involves the GP. NHS Devon noted that there does not appear to be a requirement for the paediatrician to take the lead in co-ordinating a multi-agency investigation, as per the root cause analysis (RCA) process, prior to the local case review.

It is current practice to report the death of any child as a Serious Incident Requiring Investigation.

All Serious Incidents Requiring Investigation have strict investigation and reporting criteria and procedures, with the investigation usually entailing the use of Root Cause Analysis Techniques and Tool, which may be a multi-agency root cause analysis if a number of agencies are involved in the care of the patient. NHS Devon reviews the reports, along with summaries given by the agency who reported the incident to the Strategic Health Authority, and recommends closure or further action as appropriate.

Care and service delivery problems

Care delivery (CD) and service delivery (SD) problems are points at which something happened that should not have happened; or something that should have happened did not. The following were identified through mapping information into the tabular timeline and during discussion at RCA meeting:

Cricketfield Practice

- S’s nappy was not examined on 22nd December 2010. CD (Education and Learning: Learning Point)
- No immediate contact with a member of staff at the practice after arrival at the surgery and the appointment. SD
- Lack of information in the practice regarding waiting times to see GPs. SD
- The weather was exceptionally bad with snow and frozen roads (Environment Contributory Factor)

Information given by the GPs could have been more directive regarding advice on accessing Out Of Hours care

NHS Direct

- The disposition (decision from the call) of the NHS Direct Call may not have been correct. Clarification is required from NHS Direct CD

Devon Doctors

- The escalation process for call handlers may have been followed - confirmation was required following the RCA. SD
- Devon Doctors service in the Newton Abbot Treatment Centre was exceptionally busy that night because of the weather and the time of year with an increased number of patients with flu like illnesses, there was, also another seriously sick child within the unit SD (Contributory Factor). This links with environment contributory factors identified below.
- The follow-up call back by the Out of Hours GPs, after the phone was unanswered at the initial call 21 minutes after receipt by Devon Doctors, was managed as a routine call as per NHS Direct disposition. Please note first clinical assessment for routine calls should take place within 60 minutes and face-to-face within 6 hours, however S had been clinically assessed by NHS Direct.

Following the RCA

- It has been confirmed that the call was escalated after the call handler sought advice from Newton Abbot Treatment Centre advising S’s parents to go “direct to base”. However, this escalation was not fully documented on the system and the parents were not advised that the call handler had not spoken to a clinician in gaining this advice, as the clinicians were busy with other patients.

- A call back call by S's mother was not fully documented on Devon Doctors system but safety net advice was given

SDHT

- Antibiotics were not given in A&E department CD

Patient Factors

- S's condition was a rare, rapidly deteriorating, bacterial complication of influenza which at the time had become epidemic. Some of the presenting symptoms were not indicative of the severity of the underlying condition. (Contributory Factor)

Contributory factors

- Environment

The weather was exceptionally bad with snow and frozen roads causing treacherous driving conditions

Swine flu was prevalent within the community and affecting all healthcare providers, and was recognised as an epidemic.

- Working Conditions

Devon Doctors Out of Hours GP service was exceptionally busy that night because of the weather and the time of year with an increased number of patients with flu-like illnesses, there was also another seriously sick child within the unit. SD

Root causes

The key themes identified during the RCA were

- Environment/ Working Conditions
 - The weather was exceptionally severe and there were a high number of patients in the healthcare community with flu.

- There was another extremely sick child in Newton Abbot Treatment Centre who was also transferred to SDHT and subsequently onto an Intensive Care Unit.

• Patient factors

- S's condition was a rare, rapidly deteriorating, bacterial complication of influenza which at the time had become epidemic. Some of the presenting symptoms were not indicative of the severity of the underlying condition. (Contributory Factor)

Lessons learned

Patient Factors

- Diagnosis of pneumonia: In Nov. 2009, S was seen in Torbay Hospital and Azithromycin was prescribed on the basis of X-ray changes in the left, lower zone of the chest. He was followed up in the Outpatients department in December and examination was reported to be "entirely normal". No follow-up X-ray was requested and no instructions were fed back to the surgery to consider any predisposition to future infections. The episode was not highlighted specifically on the computer as "pneumonia".(CD)

Education and Training Factors

- Checking the nappy of a febrile child: The Doctors and Triage Nurses are all now aware of the importance of checking the nappy of an unwell child with a fever, even if he/she appears adequately hydrated. (CD)
- Just In Case Antibiotics: The prescribing of delayed antibiotics is in line with the NICE guidance CG69 for respiratory infections: antibiotic prescribing. The Surgery will

continue to prescribe in this way, where appropriate, but will endeavour to give clearer instructions as to when to use the medicine. (SD)

- Awareness of Strep A infections: There has been a sudden appearance of information from the Health Protection Agency regarding Strep A infections over the winter period. The Surgery is now more aware of the increased vigilance for symptoms of septicaemia as well as meningitis, and will keep each other updated as more information arises. Already there are recommendations that will change the current prescribing habits. Penicillin V for 10 days rather than Amoxicillin for 5-7 days is preferred in suspected Streptococcal, upper respiratory infections, and anti-inflammatory drugs such as Ibuprofen are thought to reduce the body's immune response to streptococci and so paracetamol alone for managing the fever is preferred. (CD)
- Diagnosis of Asthma: This is an individual decision. The Surgery's Senior Nurse Practitioner, is very experienced in Asthma management and had seen S through some of his surgery visits for chest infections. On balance, she preferred not to label S as "asthmatic" on the basis that he showed no symptoms of asthma when there was no infection present, and so the likelihood of asthma was low. This approach is still consistent with current guidelines. (CD)
- Antibiotics were not given in A&E (antibiotics to be given as soon as prescribed)

Task Factors

- S had been fully assessed for meningitis

Communication

- Information given by the GPs could have been more directive regarding advice on accessing Out Of Hours care: Rather than just telling patients to contact OOH services if their condition deteriorates, it would be helpful to have a card with the relevant emergency OOH numbers, which can be given to patients at the time of the consultation. (SD)
- GP Computer records and display of past medical history: Selected information on the computer such as Diagnostic labels are made into a heading and highlighted so that they can be located in a summary box. The Surgery continually monitors & updates its method of clinical data entry and will strive to improve further. (SD)
- Information regarding waiting times and letting patients know who to contact if they need help could be prominently displayed within the surgery.
- Family did not answer the first call back made by the Devon Doctors GP and the Devon Doctors GP was unable to leave a message saying he had called.

Organisational and Strategic Factors

- There is a lack of availability of paediatric nurses working in A&E to give complex medications such as antibiotics, to children
- More continuity with the same GP: Although this is not always possible, the Surgery prefers patients to have continuity of care. The staff filter appointment requests to: 1) Own GP, 2) GP last seen & 3) Duty Doctor in more urgent cases. (SD)

Following the RCA process

Communication

Devon Doctors

- The Devon Doctors Call operator could have given clarity in that the GP was currently committed with a patient but that having spoken to the base receptionist the advice was that S's parents could take S straight to the treatment centre.
- The Devon Doctors call operator did not document that he had upgraded the call to urgent and that S was presenting following vomiting black liquid, though he passed it verbally to base.
- More effective communication from the receptionist with the parents on their arrival at Newton Abbot Treatment Centre in relation to letting the doctor know they had arrived would not have left the family feeling that they had been 'placed at the back of the queue'

Communication regarding the RCA Process

- The NPSA Being Open Framework recommends the best practice for clinicians are the key point of contact.
- In this situation closer liaison regarding the different aspects of the varying parts of the investigation, would have identified all agencies involved at an earlier stage and lessened the degree of confusion and improved the experience for S's parents.
- S's father noted that he would have appreciated contact by the RCA chair so he and his wife would have known exactly what was happening in relation to the investigations.
- Please note that where a child death is part of the rapid response process the co-ordination is part of the process along

with close review of preceding events with the family, which helps identify agencies involved.

- The Surgery was "not aware of their role" after S's death: There is an unwritten system which the Surgery has always operated whereby the GP of the patient (or their next of kin) is responsible for getting in touch as soon as is reasonable, by phone or visit. In this instance direct contact was complicated in the early few days because calls were answered by S's Grandmother and messages were passed on. The dilemma was whether offering support via the Grandparent was sufficient or whether the Surgery should have been more proactive with the possible risk of interfering. A lot of time was spent in discussion amongst the doctors and staff about care and support but the lack of personal contact came across as if there was a lack of interest from the Doctors. All of the practice staff feel extremely sorry that the family felt neglected — the reality could not have been further from the truth. Having discussed this issue it was realised that, as direct personal contact was not made in the early days, a card with condolences could have been written and posted. A card for this purpose has been specifically chosen. (SD)

Recommendations

- Multi-agency investigations of child deaths that do not need a Rapid Response Process should be routinely coordinated by secondary care as all child deaths are confirmed by a paediatrician who have a full history of the child's illness and agencies involved in their care. This will ensure that parents are kept informed and have one identified point of contact who will know exactly what is happening. It will also facilitate the investigative process in

determining key agencies that need to be involved.

- Where there is a complex multi-agency RCA or a Serious Incident combining more than one process it may be appropriate for the Chair of the RCA to jointly undertake the role of Being Open lead with the Clinician in order to explain the different processes in place and how they work together.
- For organisations where call recording is routine: OOH GP Service; NHS Direct; SWAST — voice recordings should be requested, submitted and reviewed at the RCA investigation meetings.
- The practice completes the process of changing the message on the Touch Screen to state that waiting times.
- The practice completes the process of amending the information on the Amscreen display to let patients know they can ask for help.
- The practice continues to provide patients with more directive information about what to do in the event of a deterioration of a febrile child and other patients who may need to contact Devon Doctors and to provide the Out-of-Hours number. This information will be in addition to that included on the answer-phone message.
- The practice continues to review children's nappies in relation to being used an incident for dehydration event though there may be not other indicators
- NHS Direct review the incident in relation to the aspects identified by the RCA as requiring clarification.

- Devon Doctors review the escalation process for call handlers and the suggested answer-phone message for GP surgeries.
- The commissioners of the MIUs are aware of this incident as a positive example of the two organisations working together.
- NHS Devon and SDHT liaise to regarding identification of suitable bereavement support services for children.

Arrangements for sharing learning

All organisations are to disseminate the learning across their organisations.

NHS Devon will disseminate the learning to other commissioners and providers of Minor Injury Services within the region.

South Devon NHS Foundation Trust will arrange for learning to be shared with A&E and paediatric practitioners

NHS Direct will arrange for learning to be shared across their call centres

Devon Doctors will arrange for learning to be shared with all practitioners and appropriate staff.

The South West Strategic Health Authority will arrange for dissemination through their learning networks.

SHA South East to disseminate in their role as lead commissioners for NHS Direct.

NHS Devon and the other health professionals involved in this investigation process wish to convey their sincere expression of regret to the family for their loss. The investigation process and findings will be used for learning and will help inform future guidance.

2.0 MAIN REPORT:

2.1 Incident Description and Background

A 3 yr 8mth year old boy S was admitted seriously ill to Torbay Hospital from Newton Abbot Treatment Centre on 22nd December 2010 following a short-flu like illness. His condition deteriorated and he died at 5:05 am on 23rd December 2010.

2.1.1 A 3yr 8mth old boy attended his GP Surgery on 21st and 22nd December 2010 amidst an epidemic of “Swine ‘flu” and during a period of severe freezing weather. After assessment, it was thought that the illness was a predominantly viral illness and not requiring antibiotics at that time. After showing signs of physical deterioration during the 22nd Dec. he was admitted to Torbay Hospital Accident & Emergency Dept. at 22:28 as a high priority emergency that evening, having previously contacted NHS Direct and Devon Doctors Ltd GP On-Call Service and attending Newton Abbot Treatment Centre. Despite diagnosing and attempting to treat a Streptococcus Group. A septicaemia complicating an Influenza B infection he deteriorated rapidly and died in the hospital at 05:05 on 23rd December.

2.1.2 S’s mother explained that S had the flu worse than the rest of the family and she was struggling to control his temperature with Calpol and Ibuprofen, which meant that he would perk up for an hour or so. She was concerned that he would get wheezy or develop a chest infection as had happened in the past.

2.1.3 On 21st December S and his family attended the Surgery as S’s brother and father also had flu - like symptoms. S’s mother also went as she was caring for the whole family. The weather was extremely cold; there was snow and ice, which made walking and driving conditions extremely treacherous. There were also a large number of patients contacting the practice with flu-like symptoms as there was a national flu epidemic at the time. The triage nurse practitioner at the practice was responsible for reviewing the daily alerts from the Department of Health and ensuring that all clinicians were informed of changes.

2.1.4 Devon Doctors Out-of-Hours treatment centre on the evening of December 22nd 2010 was extremely busy. The doctors were busy undertaking almost constant telephone consultations or seeing patients within the treatment centre. It was also noted during the RCA by the Non-Medical Consultant for Emergency and Unscheduled Care that the MIU was also busy that evening. Coincidentally there was another extremely unwell child at Newton Abbot being cared for by both the Out-of-Hours GP and the MIU nurses who was transferred by emergency ambulance to Torbay Hospital shortly before S. This other child was subsequently transferred to a paediatric intensive care unit.

2.1.5 Devon Doctors GPs receive calls from the control centre that are prioritised either by the call handler following a set protocols on receipt of a call or according to the final disposition of the nurse advisor in the case of NHS Direct referrals.

2.1.5 Initial results indicated that S had Influenza B and an invasive Group A streptococcus bacterial infection in his lungs and bloodstream.

2.2 Terms of Reference of the investigation

2.2.1 Purpose

To identify the root causes and key learning from the incident on 22nd December and use this information to significantly reduce the likelihood of future harm to patients.

2.2.2 Objectives

To establish the facts i.e. what happened (effect), to whom, when, where, how and why (root causes) This is informed by review of statements and records provided by organisation and the patients General Practitioner in relation to his/her past medical history

- To examine the adequacy of the assessments undertaken and review whether the actions consequent to the assessments were appropriate in relation to best practice and local and national guidelines
- To establish whether failings occurred in care or treatment
- To look for improvements rather than to apportion blame
- To establish how recurrence may be reduced or eliminated
- To formulate recommendations and an action plan
- To provide a report and record of the investigation process & outcome
- To provide a means of sharing learning from the incident

- To identify routes of sharing learning from the incident

2.2.3 Key questions/issues to be addressed

The scope of the meeting was to review events leading up to S’s transfer by ambulance to Torbay Hospital, actions that have been undertaken since the incident and cross agency communications. SDHT would inform the meeting with findings and recommendations from their in-house RCA.

In particular, the following aspects that were raised by S’s parents were also considered:

- Appointment times at the practice;
- Patient information regarding care of the febrile child;
- Consideration of indicators for septicaemia;
- Follow-up calls by the various organisations;
- What happened upon arrival at Newton Abbot Hospital.
- There are also some other aspects relating to the period after S arrived at Torbay Hospital that were considered by SDHT. Please see Appendix for more details.

2.2.4 Investigation type, process and methods used

- Single -incident investigation
- Gathering information: obtain written reports from all involved in the patient pathway.
- Incident Mapping: From the

- documents available, a chronology produced in order to understand the sequence of events.
- Identifying Care and service delivery problems obtained information in relation to all agencies working caring for S before his transfer to Torbay on 22nd December 2010.
 - Identifying contributory factors & root causes
- ### 2.2.5 Timescale
- The review report will be shared, for comment, with those involved in the process of review by 6th May and the final report will be submitted to the provider agencies, commissioners and NHS South West by 20th May 2011.
- ## 2.3 Investigation team
- ### 2.3.1 Devon Doctors Ltd GP Out of Hours Service (Devon Doctors)
- [Name] Head of Governance — Devon Doctors
- ### 2.3.2 Devon Provider Services (DPS) — Minor Injury Unit (MIU)
- [Name] Non Medical Consultant - DPS NHS Devon
- ### 2.3.3 GP Practice
- [Lead GP]
- ### 2.3.4 NHS Direct
- NHS Direct is undertaking its own internal investigation that is due to take place in June 2011. Information from the initial review included a chronology. The lead contact is [Name].
- ### 2.3.5 South Devon NHS Foundation Trust (SDHT) — undertook their own investigation, that will also feed into the Child Death Review Process.

- Clinical Governance Coordinator Child Health and the paediatric consultant Please see appended report.
- ### 2.3.6 Members of the Multi-Agency Root Cause Analysis Meeting 04/04/2011
- [Name] Patient Safety and Quality Manager (commissioning) NHS Devon (Chair)
- [Name] The Lead GP Cricketfield Surgery
- [Name] Non Medical Consultant — was DPS NHS Devon
- [Name] Head of Governance Devon Doctors)
- [Name] Clinical Governance Coordinator Child Health SDHT
- [Name] Lead paramedic for safeguarding children SWAST

Apologies

- [Name] Regional Lead for Clinical Governance NHS Direct
- [Name] Safeguarding Lead SWAST
- [Name] The paediatric consultant SDHT

2.4 Evidence reviewed

- Narrative from S's parents
- Chronology from Public Health Lead Nurse
- Narrative report from GPs in Cricketfield Practice regarding the consultations with S
- NHS Direct Chronology
- Devon Doctors Chronology and reference to Call Slip —

- Statement from MUI nurse and MIU Paediatric assessment sheet
- SWAST log
- Multi-agency chronology combining some of the above.

Additional evidenced reviewed following the RCA

- Voice recordings from NHS Direct and Devon Doctors.

2.5 Support and Communication for relatives and family

S's mother and father are fully aware of the Root Cause Analysis and have two key points of contact within:-

The GP practice [the lead GP],

South Devon NHS Foundation Trust [the paediatric consultant].

Consent was obtained from S's parents for information to be shared amongst all agencies.

S's mother and father also provided a narrative of S's illness and their experiences during this time. S's parents will receive a copy of this report and an opportunity to discuss it through with the lead GP and NHS Devon (chair of RCA).

Referral for counselling: the lead GP explained that a GP Partner and the Practice manager, gathered & supplied a list of web links to organisations for supporting parents, children and siblings. It would have been more helpful for the surgery to have a directory of agencies at the outset to help discussions over the choice, particularly as there was a lengthy delay in providing guidance on this issue. The situation of a sudden,

unexpected child death is, fortunately, rare in General Practice. The lead GP believes that, following an unexpected death in similar circumstances, a Rapid Response Investigation would be set up and would take on the responsibility for arranging counselling. A decision was made in this case not to initiate the Rapid Response process. It would have been more helpful if information was more freely available between the hospital and the surgery with respect to who was responsible for initiating bereavement support. No assumptions should be made under these circumstances. (SD)

[Action NHS Devon and SDHT] liaise to regarding identification of suitable bereavement support services for children.

2.6 Support for staff

Devon Provider Services, NHS Direct and Devon Doctor staff were supported by their respective line managers for the Serious Incident Process. All staff participating in an RCA are offered support.

Support for the Cricketfield GPs was provided by the practice. Support for the Out-of Hours GP was offered by Devon Doctors.

Support is provided by NHS Direct and Devon Doctors Ltd as per their internal procedures.

2.7 Chronology of events

2.7.1 Detection of the Incident

- S's death was reported by the health visitor team caring for him, and by SDHT to Torbay Care Trust.

2.7.1.2 It is current practice to report the death of a child as a Serious Incident Requiring Investigation.

2.7.1.3 All child deaths are also subject to the multi-agency Child Death Review Process and review by the Child Death Local Overview Panel.

Investigations are co-coordinated by the Child Death Rapid Response Team if the death occurs in the community or soon after arrival in an A&E department, or if there are concerns regarding the manner of the child's death. The rapid response team will co-ordinate the local case review meeting, which will form recommendations to the Local Overview Panel regarding cause of death.

If a child dies within a hospital and there are no concerns the paediatrician has a requirement to hold a multi-disciplinary local case review as per the Child Death Overview Process, which involves the GP. NHS Devon noted that there does not appear to be a requirement for the paediatrician to take the lead in co-ordinating a multi-agency investigation, as per the root cause analysis (RCA) process, prior to the local case review.

2.7.1.4 All Serious Incidents Requiring Investigation have strict investigation and reporting criteria and procedures, with the investigation usually entailing the use of Root Cause Analysis Techniques and Tool, which may be a multi-agency root cause analysis if a number of agencies are involved in the care of the patient. NHS Devon reviews the reports, along with summaries given by the agency who reported the incident to the Strategic Health Authority, and recommends closure or further action as appropriate.

2.7.1.5 NHS Devon explained that arranging the investigation had been extremely complex. Initially the impression was that S's death be reviewed as part of the Child Death Rapid Response Process which would have been coordinated by the Rapid Response Team and organisations waited to be approached by them. Once NHS Devon had contacted the Rapid Response Team on 18 January 2011 it was established that the Rapid Response Team would not be coordinating the process. It was also further complicated in that SDHT are commissioned by Torbay Primary Care Trust as are SWAST. The key issue was then trying to determine who had responsibility to arrange the multi-agency RCA as per the SIRI process and the decision was made that it was commissioning.

2.7.1.6 Based on the information provided by DPS Public Health Team the following organisations and specialties were identified as being key members of the RCA: South Devon NHS Foundation Trust A&E department, Devon Provider Services Public Health team and Cricketfield Practice. Invitations were sent to the Patient Safety and Quality leads of DPS and SDHT asking them to identify appropriate members of staff to attend.

This meeting was extremely difficult to arrange due to availability but also that the meeting had to be rescheduled based on receipt of further information at various stages that key agencies / specialties were not invited, and that the RCA would not have been meaningful without them. It was then later established that SDHT had carried out their own RCA and was expecting that a "community multiagency RCA"

would feed into the overview panel, along with their own report.

2.7.1.7 Learning Point identified following from discussion

This was a complex investigation to arrange as it was multi-agency, coincided with the Child Death Review Process, and crossed commissioning boundaries so there was discussion regarding who was the responsible commissioner. This was further complicated by the information available to the commissioner. The commissioner does not have access to all the information and in this situation had information that was based upon reports made by the public health teams and the practice who were unaware of the involvement of NHS Direct, the Out of Hours GP service, the MIU and SWAST at the time of initial reporting. This confusion and range of meetings have been difficult for S's parents to make sense of the process and made them feel that they were not kept informed of all that was happening, even though they were seeing the paediatric consultant and the lead GP.

2.7.1.8 Recommendation

Multi-agency investigations of child deaths that do not need a Rapid Response Process should be coordinated by secondary care as all child deaths are confirmed by a paediatrician who have a full history of the child's illness and agencies involved in their care. This will ensure that parents are kept informed and have one identified point of contact who will know exactly what is happening. It will also facilitate the investigative process in determining key agencies that need to be involved

2.7.1.9 NHS Direct and Devon Doctors both reviewed call records following the RCA. These have since been shared with the family and other members of the RCA Team.

2.7.1.10 Recommendation

For organisations where call recording is routine: OOH GP Service; NHS Direct; and SWAST — voice recordings should be requested, submitted and reviewed at the RCA investigation meetings.

2.7.1.11 Discussion with S's father 13/5/2011

S's father stated that he found the processes disconnected and difficult to establish what meetings were happening and why. He stated that it would have been appropriate for him and his wife to have been contacted directly by the Chair of the RCA, as they knew the key points of contacts with the different agencies.

2.7.1.12 Learning Point identified from discussion with S's father 13/5/2011

The NPSA Being Open Framework recommends the best practice for lead clinicians to be the key point of contact. In this situation closer liaison regarding the different aspects of the varying parts of the investigation, would have identified all agencies involved at an earlier stage, and lessened the degree of confusion and improved the experience for S's parents. Please note that where a child death is part of the rapid response process the co-ordination is part of the process along with close review of preceding events with the family, which helps identify agencies involved. S's father noted that he would have appreciated contact by the RCA chair as he and his wife knew

exactly what was happening in relation to the investigations.

2.7.1.13 Recommendation

Where there is a complex multi-agency RCA or a Serious Incident combining more than one process it may be appropriate for the Chair of the RCA to jointly undertake the role of Being Open lead with the Clinician in order to explain the different processes in place and how they work together.

2.7.2 Chronologies, narratives and statements

The chronologies and statements from all agencies were reviewed in detail, with some minor aspects requiring clarification.

The narrative from S's parents was reviewed first and the key points they raised were kept in mind when the chronologies were reviewed.

Discussion of the chronologies / narratives identified eight points of contact with the patient or his mother by health services on 21st and 22nd December 2010 prior to his arrival by ambulance at Torbay Hospital. Points noted in the report were raised during the meeting on 4th April 2011 and reflect the discussion at the time.

2.7.3 Chronology provided by the Public Health Nurses

2.7.3.1 This provided a summary of the key points of contact with the public health service since S was born. The lead GP stated that there had been no major concerns antenatally for S or later on. He did note that in 2009 S had been admitted to Torbay Hospital with a chest infection that required antibiotics. Prior to admission no clinical

signs of infection had been picked up on listening to the chest and there was a notable symptom of abdominal pain. The hospital chest X-ray showed "changes in the left lower lobe". He made a full recovery and no specific recommendations were suggested for future care.

2.7.3.2 Learning Point identified following from discussion

Although there were some similarities in the presenting symptoms between the 2009 admission and the recent illness (lack of chest signs and abdominal pain) the infective organisms were likely to have been completely different

2.7.4 Cricketfield Practice — first point of contact on 21st December 2010

2.7.4.1 21/12/2010 S and his family attended the surgery for a joint consultation as S, his brother and father all had flu-like symptoms. S had a fever, cough, a fine rash on his body and vomiting.

2.7.4.2 The lead GP summarised the key points of the narrative report provided by his colleague.

2.7.4.3 His colleague had thoroughly examined S and concluded that he had a flu-like illness. He reviewed him for meningitis as he had a fine rash, the rash reduced with gentle pressure to the skin. There were no clinical indications of pneumonia. The vomiting he had been experiencing was usually after a period of coughing. However, in view of Christmas and as his symptoms he decided to prescribe a delayed script for amoxicillin, an antibiotic, in case his symptoms worsened. He gave S's parents advice regarding flu and the role antibiotics play.

2.7.4.4 The doctor also examined S's brother

and father and concluded they also both had flu-like illnesses.

2.7.4.5 Following the news of S's death the GPs within the practice reviewed the guidance from the DOH in relation to swine flu and flu and guidance in relation to antibiotic prescribing for respiratory infections.

2.7.4.6 Learning Points identified following from discussion

- There were a large number of patients with swine flu
- The prescribing of delayed antibiotics is in line with the NICE guidance CG69 for respiratory infections: antibiotic prescribing.
- Amoxicillin is now determined as not being the antibiotic of choice for bacterial Group A streptococcus infections.
- Recent Guidance states that Ibuprofen should not be given to patients with suspected septicaemia, as there is a risk of increasing the effect of the toxins.
- It is rare for a bacterial Group A streptococcus infection to be a complication of flu.

2.7.4.7 Notable Practice

The Lead practice Nurse / Triage Nurse reviews all alerts relating to flu and swine flu and ensures that everyone is aware of the latest guidance

2.7.5 Cricketfield Practice — second point of contact on 22nd December 2010

2.7.5.1 S's mother contacted the surgery at 10:45 and was placed on the telephone triage list. The triage nurse rang S's mother at 13:50 and subsequently

requested the duty doctor to ring S's mother as she had picked up in the discussion that S's mother was anxious. The duty doctor rang S's mother at 14:00. S's mother explained that S had deteriorated since the 21st December, and as he had got worse and S's mother had some ongoing concerns he encouraged her to bring S to the surgery at 16:10. The lead GP said the duty doctor had told him he felt this time was more appropriate as the road conditions would have improved.

2.7.5.2 After arrival at the surgery the receptionist offered S's mother a glass of water for S. The duty doctor examined S at 16:30, he was obviously unwell and not wanting to interact much. On examination, his respiratory rate was normal, chest was clear and his throat showed no obvious focus of infection. The rash, which had not changed from the previous day and blanched on pressure, was more in keeping with a viral rash than meningitis. On discussion with S's mother, [the duty doctor] satisfied himself that S was managing to drink enough and did not appear to be dehydrated. S chatted briefly at the end of the consultation, did not appear to be confused or disoriented. The duty doctor determined that as there were no signs of a secondary bacterial infection and he could not see any clear indication to start antibiotics the measures his mother was doing already was sufficient. S's mother agreed, they also discussed the need for further medical review either at the surgery or with the Out of Hours service should S's condition deteriorate.

2.7.5.3 The lead GP explained that on discussion with S's parents following S's death some points had been raised by

them regarding their experience in the waiting room at the surgery.

- Experience in the Waiting Room: “How late are they running?” — the lead GP noted that it has been agreed to programme the touch-screen used to book-in patients to inform patients if, and by how much, the GP is running late. (SD)
- Reception is unfriendly: the lead GP explained that the touch-screen is used to avoid queues at the Reception area and allow the Reception staff to be free to do other duties. Messages appear on the screen instructing patients to seek help from the receptionists if problems arise with the book-in process. The original design for the Reception desk was completely “open plan”. After a period of time, however, it was decided to enclose the front desk with a glass partition with openings. The Partners have had discussions for some time about re-designing the front desk to try to lose the window barrier and have been waiting for the arrival of the new Practice Manager to take the project forward. Plans have now been drawn up. It is hoped that the new design will bring back a more friendly Reception area. (SD)
- “Need a big sign to let me know I can come and ask for help”: There is an Amscreen on the wall in the waiting area that continuously broadcasts information relating to health issues. It is believed that this is programmable and

that the Surgery is able to add their own messages to the effect that, “If anyone in the waiting room requires the assistance of a Receptionist or is worried about the seriousness of their condition, please report to the Front desk.” A poster will be placed on the notice board in the upstairs waiting area with the same information. The screen and poster will not always be visible to everyone seated in the waiting areas but it is hoped that, with the new design of the Reception area, patients will feel able to seek assistance if required. (SD)

2.7.5.4 Action Points

The practice is in the process of changing the message on the Touch Screen include waiting times

The practice is in the process of amending the information on the Amscreen information display to include a message if assistance is required.

- 2.7.5.5 S’s mother wanted to know why S’s nappy had not been checked and if the GP was aware that her son’s other symptoms are also indicators of septicaemia. It was agreed that the duty doctor had thoroughly assessed S for meningitis. At the time his clinical signs did not indicate a septicaemia. As stated earlier it was acknowledged that septicaemia is a rare complication of flu and is not a condition that is usually considered early in the pathway of an illness, as the symptoms are also indicative of other more common illnesses. S had been able to drink so was unlikely to be dehydrated. It was

generally accepted that, on reflection, knowing that the nappy had been dry for over 6 hours may have influenced the decision at the time.

2.7.5.6 Learning Points from discussion.

- It was agreed that knowing if a nappy is dry and when it was last changed is an important indicator, especially if other signs are not representative of dehydration and the practice have taken this learning on board. In the future the GP’s will be more actively checking the nappy as part of an assessment of a child with a febrile illness.

- 2.7.5.7 S’s mother also raised a question regarding the importance of ‘safety netting’ and giving information regarding this when a febrile child is sent home. It was agreed that information had been given but may not have been specific enough, especially in relation to obtaining Devon Doctors out of Hours number. The practice has a standard answer phone message on their phone that starts with a message about 999 and then goes through the various organisations to contact depending on the condition of the patient. At the time of the RCA the sequence of events was not known but S’s mother clarified that she had hung up when she realised the surgery was closed and rang NHS Direct’s number.

2.7.5.8 Action Points

The practice had already reviewed the aspect regarding information given to patients when a febrile child is sent home and have agreed to provide patients with more directive information about what to do in the event of a deterioration and to provide

the Out-of-Hours number rather than directing them to listen to the answer-phone message.

Devon Doctors to review advised answer-phone messages for practices to ensure that the advice is clear and in the correct order.

- 2.7.5.9 In response to a question from S’s mother regarding whether the GP had made an assumption that he hadn’t heard a chest problem that was there, the group agreed based on the evidence provided the duty doctor had assessed S as well as possible and X-rays are not available to GPs. It was acknowledged that GPs are not the expert to give the answer but the group said that he had made a decision based on his clinical judgement and the clinical presentation at the time did not support a chest problem.

2.7.6 NHS Direct — third point of contact on 22” December 2011

- 2.7.6.1 NHS Direct received a call from S’s mother at 18:20 as she thought that S had vomited some blood as there were black streaks in his clear vomit (he was very thirsty continuously sipping water). A Health Advisor took the call and undertook an initial assessment of S’s symptoms using the Vomiting Under 12 year’s old protocol. The call was transferred straight way to the nurse advisor as a Priority 1 call. The Nurse advisor launched the Vomiting: Toddler (aged 1-4) algorithm to assess S’s symptoms and arrived at the decision (disposition) to refer to primary care services the same day. The clinical summary stated “Vomiting for tonight and was seen by the DR yesterday and at 4pm today”. Has not passed urine since this morning, mouth very dry and

complaining of pain in his penis". The call was closed after 22 minutes and a message sent to Devon Doctors via technical link.

2.7.6.2 NHS Direct were unable to attend the meeting due to the short notice as the regional clinical governance lead had been on holiday when the invitation was sent and unable to rearrange her commitments. However, she had been able to arrange a quick review of the incident by their children's lead and the development of the chronology. She stated that the incident would be reviewed by the national incident review group and recommendations made as appropriate. She also stated that the disposition of the call as routine would be reviewed closely as part of this process, as the child health lead indicated that it may have been more appropriate for the call to have been classed as urgent

2.7.6.2. A number of areas requiring clarification were raised including:-

- The NHS Direct Dispositions that was sent to Devon Doctors included the initial message referring to "vomiting brown lumps 5M" which is not included in the clinical summary.
- Confirmation that the algorithm was completed appropriately in view of lumps being present in the food and concern regarding urine output.
- Review of the transcripts and confirmation that all the questions on the algorithms had been asked.
- Copy of the final NHS Direct report

2.7.6.3 Action Points

[NHS Devon] to contact [NHS Direct] with the above areas for clarification

2.7.6.4 **Update from NHS Direct following their internal peer review meeting held 3rd June 2011:** The initial findings from the preliminary investigation carried out prior to the RCA were that the Nurse Advisor should have passed this referral through to the GP OOH service as 'Urgent', requiring consultation within two hours, rather than 'routine', requiring consultation within six hours. This information along with the timeline of events within the NHS Direct contact was made available to NHS Devon for the RCA meeting on the 4th April 2011. NHS Devon was advised that this case was subject to an internal investigation termed within NHS Direct as an Incident for National Review (IfNR), which would result in a National Peer Review of the investigation findings (NPR) and on completion of that NHS Devon and the RCA would be further updated. The NPR was held on the 3rd of June and a letter written to Mr Morrish outlining the findings of the investigation and the NPR panel copied to NHS Devon for the purposes of inclusion in the RCA report. The NPR panel agreed with the initial investigation findings that a more urgent referral should have been made to Speak to a GP within two hours or to attend A&E should have been given by the Nurse Advisor.

2.7.6.5 With regards to the specific questions posed from the initial RCA meeting (section 2.7.6.2 above) NHS Direct have the following responses (already shared on 20.06.2011)

- The NHS Direct Disposition that was sent to Devon Doctors included the initial message referring to "vomiting brown lumps 5M" which is not included in the clinical summary.

NHS Direct Response: "vomiting brown lumps 5M" was in the 'Call Reason' field in NHS Directs patient record, which is typed by the NHS Direct Health Advisor taking the initial call — staff are trained to document the initial statement that the caller says is their concern. This is left unchanged throughout the patient journey and this should be the main reason articulated by the caller for the call at the time it was received. This remains unchanged in order to keep an audit trail and is visible to Devon Doctors. The Nurse Advisor can add comments into the call summary field and could have referred to the nature of the vomit there but omitted to do so. Also where the question in the algorithm regards whether the toddler is vomiting blood or coffee ground fluid is asked the nurse advisor could and should have qualified her "No" answer with a description of the clear vomit with 'brown lumps and streaks'.

- Confirmation that the algorithm was completed appropriately in view of lumps being present in the food and concern regarding urine output.

NHS Direct Response: The correct algorithm of 'Vomiting toddler' was used by the Nurse Advisor to assess S's symptoms. There was no specific question asked about brown lumps but there was one regarding vomiting blood or coffee grounds. The Nurse Advisor probed around the nature of the vomit and suggested to Mrs Morrish she did not think that this sounded like blood and she proceeded past this question to assess S's symptoms further. The algorithm used did include questions around urine output and drinking. The Nurse Advisor recognised that S was showing signs of dehydration and talked

to Mrs Morrish regarding that and this prompted the referral to the GP OOH service for further medical assessment.

- Review of the transcripts and confirmation that all the questions on the algorithms had been asked.

NHS Direct Response: All questions within the algorithm were asked. The review has identified some issues as outlined below. A review of this call was done at the time NHS Direct was initially made aware of this case. That review showed that the correct algorithm had been used and the Nurse Advisor, on assessing the nature of the vomit, chose to answer "No" to the presence of blood or coffee ground fluid. This doesn't appear to have been by mistake but a considered judgement to answer "No" and assess further around other symptoms. Further questions were asked but the review identified that the answers recorded were not consistent with answers provided for example a "No" answer was recorded against the presence of rapid breathing when Mr and Mrs Morrish had clearly stated "Yes". In addition the question regarding rash was answered in the record, but not probed sufficiently. The Nurse Advisor should have requested that Mrs Morrish check Samuel's rash again for signs of any change.

2.7.6.6 In respect of NHSD Directs Learning Points: the review of the call identified individual learning for the Nurse Advisor involved and these are being addressed and the Nurse Advisor will continue to have increased support and monitoring for a further 3 month's. In addition NHS Direct shares the learning from IfNRs (anonymised) across the organisations to ensure that the importance of critical

thinking, listening and ‘hearing’ callers’ or patients’ concern, being clear in the questioning of callers to ensure answers reflect the situation and the importance of accurate documentation is emphasised to staff at every opportunity.

2.7.7 Devon Doctors — fourth point of contact on 22nd December 2011

2.7.7.1 The message from NHS Direct was received via technical link at the Devon Doctors Control Centre at 18:44 and dispatched, to the Newton Abbot treatment Centre at 18:48 for Devon Doctor clinical triage, as routine, as per the final disposition from NHS Direct following clinical assessment and subsequently acknowledged at 18:51.

2.7.7.2 There was one triage doctor on duty until 19:00 when he was joined by a second doctor. Both doctors were making triage calls as per their priority status and seeing patients in the treatment centre.

2.7.7.3 The duty doctor rang S’s home at 19:12 but there was no answer. He then rang back at 21:19 when the phone was engaged. In the intervening period the duty doctors had made 24 telephone consultations plus 10 face-to-face consultations, excluding other calls in relation to another sick child who was later seen at Newton Abbot Hospital.

2.7.7.4 Additional Information following discussion with S’s father.

Following discussion with S’s father, the Devon Doctors became aware that there was in fact an earlier call made by S’s mother to Devon Doctors control centre. This call was made at

20:52 hours, which was not physically logged on the call slip as a ‘call back’ and was made from a mobile phone. Because the call back did not show on the call slip and the only reference to the mobile phone number was made later (when it was arranged for the family to attend the treatment centre) a search of the mobile number on the software was not made. In this call S’s mother was questioning if she had missed the doctors call. No mention was made of S’s condition. Whilst the operator did not physically record the call back, she did follow due process by alerting the base that the call back had been received and safety net advice was given in the event of not hearing within a timescale. This has highlighted a learning need for this operator in relation to documentation. Devon Doctors Governance Team also recognise that a search on the mobile number should have been made which would have found the call.

2.7.7.5 Learning Point

A call back call by S’s mother was not fully documented on the Devon Doctors system but safety net advice was given.

2.7.7.6 At the same time that the duty doctor called S’s home at 21:19 S’s mother was ringing the Devon Doctors control centre as she had not heard back from Devon Doctors. The call handler was unable to pass the call to either GP as they were both busy with patients and on discussion with the driver at Newton Abbot took the decision to advise S’s mother to bring him to Newton Abbot treatment centre.

2.7.7.7 The group discussed the decision of the call handler and the driver to advise

S’s mother to attend Newton Abbot treatment centre as they felt unable to interrupt the doctors. [Devon Doctors] stated that the guidelines recommend in the event of concerns of the patient / carer that the appropriate action would be to advise them to get the patient clinically assessed as soon as possible. This would be partly based upon what original rating the call had been given. If the call had been rated as urgent it would have been coloured orange indicating that a more rapid outcome was required.

2.7.7.8 Action

[Devon Doctors] will review the escalation process for call handlers and the call at 21:18.

2.7.7.9 Following the action above it has been confirmed that the call was escalated appropriately after the call handler sought advice from Newton Abbot Treatment Centre advising S’s parents to go “direct to base”. However this escalation was not fully documented on the system and the parents were not advised that the call handler had not spoken to a clinician in gaining this advice as the clinicians were busy with other patients. It has also been noted that the usual practice is to pass calls through the treatment centre receptionist, who may sometimes be a driver as they are dual trained. However, Devon Doctors recognise that there is learning in relation to communication

2.7.7.10 One question raised by S’s mother was whether S would have been seen sooner if he had been taken straight to Torbay. The group agreed that it was difficult to answer this question but he was seen within 20 minutes from

arrival at Newton Abbot at 21:38 by the MIU nurse and Devon Doctor GP who contacted SWAST and the SDHT Torbay paediatric team. The ambulance was called at 22:01, arrived at 22:04, left at 22:18 after a handover and arrived at Torbay Resuscitation at 22:28, 50 minutes after arrival at Newton Abbot. The group knew that Torbay A&E were busy and were not sure if the time taken for S’s mother to take him to Torbay and then register at A&E would have been longer or shorter.

2.7.8 Devon Doctors Treatment Centre Newton Abbot on 22nd December 2010 — Reception - fifth point of contact

Please note that the Newton Abbot Treatment centre is co-located with Newton Abbot Minor Injury Unit within Newton Abbot Hospital.

2.7.8.1 S arrived with his mother at 21:38 at Newton Abbot and registered with the receptionist.

2.7.8.2 The second duty doctor left the treatment centre after 21:24 to go on a home visit, returning at approximately 22:10

2.7.8.3 S’s mother wanted to know if “receptionists were aware of patient symptoms and if it was normal to make children who had not weed for almost 12 hours and vomiting blood to wait in a queue”. [Devon Doctors] confirmed that the receptionists are not clinical and whilst they are aware of the clinical information, they cannot make clinical decisions. They can however, make recommendations as to the access to the various services but this should be communicated clearly to the caller.

2.7.8.4 The group also agreed that it would not be appropriate to make a child wait who had not passed urine for 12 hours if this was known but clarification is required from NHS Direct regarding the call with the nurse advisor.

2.7.9 Newton Abbot Community Hospital Minor Injury Unit Devon Doctors treatment Centre on 22nd December 2011 - MIU nurse and Devon Doctor Duty Doctor - sixth and seventh points of contact

2.7.9.1 From the MIU nurse statement: The MIU nurse came out of the treatment room at approximately 21:55, after having previously been helping the Duty Doctor set up some intravenous fluids for another patient who had an ambulance waiting, she noticed that a young child in his mother's arms was looking extremely unwell - (it does not mention in the statement how she came to notice S). She asked the Devon Doctor's receptionist the name of the child and advised the receptionist that she was taking the child straight through to the resuscitation room. S's dad joined his son and wife as they were taken through the unit. At 21:58 she assessed S using a paediatric assessment form that was being trialled at the time. The form includes a traffic light system for assessing whether the child is low, intermediate or high risk. S had complied with three intermediate-risk criteria and three high-risk criteria. As one high-risk criterion is an indication for immediate referral to acute hospital via 999 the nurse advised her colleagues of the need to call an ambulance, the nurse then carried out further

observation and administered oxygen that improved S's oxygen saturation levels. The duty doctor dialled 999 and informed the paediatric team at Torbay and then handed over to the ambulance crew on their arrival at 22:04

2.7.9.2 The Devon Provider Services representative noted that the timing of the Devon Doctor entry was earlier than the time noted by the nurse when she assessed the patient. [Devon Doctors] noted that due to the situation, there is a possibility that the records by the duty doctor would have been written after the event and the time of intervention approximated. The time recorded by the MIU nurse was when she had taken the observations.

2.7.9.3 The main discussion regarding this point of contact centred around what happens to patients on arrival to an MIU, after they have been triaged to attend a Devon Doctor Treatment Centre that happens to be co-located within an MIU. It was agreed that the intervention of the nurse was timely and it was agreed that she also had no accountability for S as she was employed by DPS and S was a Devon Doctor patient. The Devon Provider Services representative explained that the issue of accountabilities had been raised previously in other arenas, with the outcome of a specific commissioning meeting to look at these issues. The Devon Provider Services representative noted that it was acknowledged that arrangements needed to be formalised to reduce the risks of patients deteriorating whilst waiting to be seen. For example a Devon Doctor patient that is rapidly deteriorating in a waiting area with the

GP busy with other patients or away on visits and the MIU nurses being busy with other patients and not able to intervene in a timely manner. The group agreed that this is an example of good teamwork between the two different agencies, especially as call volumes were so high coupled with the attendance of two seriously ill children at the same time and demonstrates the importance that Devon Doctors and DPS place on clinical need,.

2.7.9.4 Action Point

The Devon Provider Services representative to take the findings of this RCA to the commissioning meeting

2.7.9.5 Notable Practice

At the RCA it was agreed that the intervention of the MIU nurse when she saw that S looked unwell demonstrated notable practice.

2.7.10 SWAST — eighth point of contact on 22nd December 2011

2.7.10.1 The ambulance service representative stated that the timings provided by the ambulance crew in relation to arrival and departure times are automated so therefore accurate. The ambulance was called at 22:01, arrived at 22:04, left at 22:18 after a handover and arrived at Torbay A&E Resuscitation bay at 22:28, 50 minutes after arrival Newton Abbot. He noted that the crew was an Ashburton Crew who had been close by, the Newton Abbot Crew had just left to take another patient from the MIU to Torbay Hospital.

2.7.11.2 The ambulance service representative stated that the ambulance crew noted that S had a bilateral wheeze.

2.7.10.2 The ambulance service representative acknowledged that he had been informed of the meeting on the Friday 1st April 2011 but had been able to obtain the calls logs and discuss the callout with one of the paramedics, who said that there had been no concerns regarding previous care of S.

2.7.11 South Devon Healthcare NHS Foundation Trust

2.7.11.1 The Trust representative explained that SDHT had undertaken their own investigation and no issues relating to S's care prior to his arrival had been raised. The summary report of that investigation was shared with the group.

2.7.11.2 The key point from the Trust investigation relates to the time after S's arrival at A&E. Antibiotics had been prescribed in A&E but had not been administered until after his arrival on the ward. The Trust representative noted that part of the problem appears to be the lack of a paediatric nurse overnight in A&E, combined with reluctance for A&E staff to calculate doses for children and administer them. This appears to be the picture nationally as there is a shortage of paediatric trained nurses working in A&E. Nurses in A&E can also request doctors to do the calculations and administer the first doses.

2.7.11.3 The Trust representative also noted that three seriously ill children had been to HDU (High dependency Unit) that night and one child had been transferred to a paediatric ITU.

2.7.11.5 The Trust representative also noted that 02:30 on 23rd December in the paediatric ward S had been sitting on his mother's lap eating a biscuit and

having a drink. An hour later he required support from the ITU consultant and the paediatric registrar called the Bristol Paediatric Intensive Care Unit. S's condition deteriorated and he required full resuscitation following cardiac arrest at 03:55 and he was sadly declared dead at 05:05.

- 2.7.11.4 The Trust representative and the lead GP both raised concerns in trying to find bereavement support for the S's older brother and the rest of family. The person who manages both the PALS and Complaints teams within NHS Devon agreed to work with the Trust to try to find some suitable support services that the Trust can automatically refer children to for support.

Action

NHS Devon and SDHT to liaise regarding identification of suitable bereavement support services for children

- 2.7.11.5 S's mother had asked why hospitals were unable to access details of her son's previous visits to the GP. Discussion amongst the group confirmed that the current IT systems do not allow access to another organisation's systems to view information. The current exception is where GPs can post a special message from via Devon Doctors website onto the Devon Doctors system, these usually relate to chronic conditions or significant issues such as palliative care. Devon Doctors, amongst others are still unable to access the main GP system. This is a national issue and the National IT Programme Connecting for Health created with the aim of a creating a single patient record is not yet achieved.

2.7.12 Other issues raised by S's mother

- 2.7.12.1 Three questions relating to a delay in the administration of antibiotics, the time when the possibility of septicaemia was first suspected and why the known symptoms of septicaemia are relate to S's time at SDHT and the Trust representative will take these back to the paediatric consultant.
- 2.7.12.2 The final issue raised by S's mother relates to her perception that the treatment and contact her son had with the NHS was subject to delays with every agency he met.
- 2.7.12.3 The group discussed this after reviewing all the chronologies and evidence. It was concluded by the group that there had been no intentional delays and no unexplained moments that would have constituted a delay. It was agreed that the illness was rapid in it's development, is an extremely rare complication of flu and is that the urgency of S's illness was not supported by the clinical picture, the group also noted that the first presentation of a bilateral wheeze was during the time he was under the care of the ambulance crew.

2.8 Notable practice identified during the RCA

- 2.8.1 The Lead practice Nurse / Triage Nurse in the practice reviews all alerts relating to flu and swine flu and ensures that everyone is aware of the latest guidance.
- 2.8.2 The GPs in the practice saw and assessed S on two consecutive days rather than just giving telephone advice. They appreciated his mother's concerns.
- 2.8.3 The recognition of the MIU nurse that S was unwell and taking prompt action

- 2.8.4 The Lead GP commented that the receptionist offered S's mother a drink during her visit to the surgery on 22nd December and that this was appreciated by S's Mother. This kind of compassionate gesture is to be encouraged.

2.9 Problems / Contributory Factors Identified

Care delivery (CD) and service delivery (SD) problems are points at which something happened that should not have happened; or something that should have happened did not. The following were identified through mapping information into the tabular timeline and during discussion at RCA meeting.

2.9.1 Cricketfield Surgery

- S's nappy was not examined on 22nd December 2010. CD (Education and Learning: Learning Point)
- No immediate contact with a member of staff at the practice after arrival at the surgery and the appointment. SD
- Lack of information in the practice regarding waiting times to see GPs. SD
- The weather was exceptionally bad with snow and frozen roads (Environment Contributory Factor) Information given by the GPs could have been more directive regarding advice on accessing Out Of Hours care

2.9.2 NHS Direct

- The disposition of the NHS Direct Call may not be have been correct clarification is required from NHS Direct CD

2.9.3 Devon Doctors

- The escalation process for call handlers may have been followed confirmation is required following the RCA SD (see below for more details)
- The Devon Doctors service in the Newton Abbot Treatment Centre was exceptionally busy that night because of the weather and the time of year with an increased number of patients with flu like illnesses, there was also another seriously sick child within the unit SD (Contributory Factor) This links with environment factors identified in 2.9.4
- The follow-up call back by the Out of Hours GPs, after the phone was unanswered at the initial call 21 minutes after receipt by Devon Doctors, was managed as a routine call as per NHS Direct disposition. Please note first clinical assessment for routine calls should take place within 60 minutes and face to face within 6 hours, however S had been clinically assessed by NHS Direct.

Following the RCA:

- It has been confirmed that the call was escalated after the call handler sought advice from Newton Abbot Treatment Centre advising S's parents to go "direct to base". However, this escalation was not fully documented on the system and the parents were not advised that the call handler had not spoken to a clinician in gaining this advice as the clinicians were busy with other patients.
- A call back call by S's mother was not fully documented on the Devon Doctors system but safety net advice was given

2.9.4	SDHT	rapidly deteriorating, bacterial complication of influenza which at the time had become epidemic. Some of the presenting symptoms were not indicative of the severity of the underlying condition. (Contributory Factor)	patients with more directive information about what to do in the event of a deterioration of a febrile child and other patients who may need to contact Devon Doctors and to provide the Out-of-Hours number. This information will be in addition to that included on the answer-phone message.	was requested and no instructions were fed back to the surgery to consider any predisposition to future infections. The episode was not highlighted specifically on the computer as “pneumonia”. (CD)
2.9.3	Patient Factors			
	S’s condition was a rare, rapidly deteriorating, bacterial complication of influenza which at the time had become epidemic. Some of the presenting symptoms were not indicative of the severity of the underlying condition. (Contributory Factor)			
2.9.4	Environment			
	<ul style="list-style-type: none"> - The weather was exceptionally bad with snow and frozen roads causing treacherous driving conditions - Swine flu was prevalent within the community and affecting all healthcare providers, and is recognised as an epidemic. 			
2.10	Analysis — include problem solving tools			
	Analysis was based on the NPSA Contributory Factor Classification framework and the Fishbone tool:			
2.11	Root Causes			
	The key themes identified during the RCA was the			
	<ul style="list-style-type: none"> • Environment / Working Conditions <ul style="list-style-type: none"> - The weather was exceptionally severe and there were a high number of patients in the healthcare community with flu. - There was another extremely sick child in MIU who was also transferred to SDHT and subsequently onto an Intensive Care Unit. • Patient factors <ul style="list-style-type: none"> - S’s condition was a rare, 			
		2.12	Recommendations	
		2.12.1	Multi-agency investigations of child deaths that do not need a Rapid Response Process should be coordinated by secondary care as all child deaths are confirmed by a paediatrician who have a full history of the child’s illness and agencies involved in their care. This will ensure that parents are kept informed and have one identified point of contact who will know exactly what is happening. It will also facilitate the investigative process in determining key agencies that need to be involved	
		2.12.2	Where there is a complex multi-agency RCA or a Serious Incident combining more than one process, it may be appropriate for the Chair of the RCA to jointly undertake the role of Being Open lead with the Clinician in order to explain the different processes in place and how they work together.	
		2.12.3	For organisations where call recording is routine: OOH GP Service; NHS Direct; SWAST — voice recordings should be requested, submitted and reviewed at the RCA investigation meetings.	
		2.12.4	The practice completes the process of changing the message on the Touch Screen to state waiting times.	
		2.12.5	The practice completes the process of amending the information on the Amscreen display to let patients know they can ask for help.	
		2.12.6	The practice continue to provide	
		2.12.7	The practice continues to review children’s nappies in relation to being used as an indicator for dehydration even though there may be not other indicators.	
		2.12.8	NHS Direct review the incident in relation to the aspects identified by the RCA as requiring clarification.	
		2.12.9	Devon Doctors review the escalation process for call handlers and the suggested answer-phone message for GP surgeries.	
		2.12.10	The commissioners of the MIUs are aware of this incident as a positive example of the two organisations working together.	
		2.12.11	NHS Devon and the Trust representative liaison to regarding identification of suitable bereavement support services for children.	
		2.13	Lessons Learned	
			The following learning points were identified	
		2.13.1	Patient Factors	
			<ul style="list-style-type: none"> - Diagnosis of pneumonia: In Nov. 2009, S was seen in Torbay Hospital and Azithromycin was prescribed on the basis of X-ray changes in the left, lower zone of the chest. He was followed up in the Outpatients department in December and examination was reported to be “entirely normal”. No follow-up X-ray 	
		2.13.2	Education and Training Factors	
			<ul style="list-style-type: none"> - Checking the nappy of a febrile child: The Doctors and Triage Nurses are all now aware of the importance of checking the nappy of an unwell child with a fever, even if he/she appears adequately hydrated. (CD) - Just In Case Antibiotics: The prescribing of delayed antibiotics is in line with the NICE guidance CG69 for respiratory infections: antibiotic prescribing. The Surgery will continue to prescribe in this way, where appropriate, but will endeavour to give clearer instructions as to when to use the medicine. (SD) - Awareness of Strep A infections: There has been a sudden appearance of information from the Health Protection Agency regarding Strep A infections over the winter period. The Surgery is now more aware of the need for increased vigilance for symptoms of septicaemia as well as meningitis and will keep each other updated as more information arises. Already there are recommendations that will change the current prescribing habits. Penicillin V for 10 days rather than Amoxicillin for 5-7 days is preferred in suspected Streptococcal, upper respiratory infections, and anti-inflammatory drugs such as Ibuprofen are thought to reduce the body’s immune response to streptococci and so paracetamol alone for managing the fever is preferred. (CD) 	

- Diagnosis of Asthma: This is an individual decision. The Surgery's Senior Nurse Practitioner, is very experienced in Asthma management and had seen S through some of his surgery visits for chest infections. On balance, she preferred not to label S as "asthmatic" on the basis that he showed no symptoms of asthma when there was no infection present, and so the likelihood of asthma was low. This approach is still consistent with current guidelines. (CD)
- Antibiotics were not given in A&E (antibiotics to be given as soon as prescribed)

2.13.3 Task Factors

S had been fully assessed for meningitis

2.13.4 Communication

- Information given by the GPs could have been more directive regarding advice on accessing Out Of Hours care: Rather than just telling patients to contact OOH services if their condition deteriorates, it would be helpful to have a card with the relevant emergency OOH numbers, which can be given to patients at the time of the consultation. (SD)
- GP Computer records and display of past medical history: Selected information on the computer such as Diagnostic labels are made into a heading and highlighted so that they can be located in a summary box. The Surgery continually monitors & updates its method of clinical data entry and will strive to improve further. (SD)
- Information regarding waiting times and letting patients know who to contact if they need help could be

prominently displayed within the surgery.

- Family did not answer the first call back made by the Devon Doctors GP and the Devon Doctors GP was unable to leave a message saying he had called.

2.13.5 Organisational and Strategic Factors

- There is a lack of availability of paediatric nurses working in A&E to give complex medications such as antibiotics, to children
- More continuity with the same GP: Although this is not always possible, the Surgery prefers patients to have continuity of care. The staff filter appointment requests to: 1) Own GP, 2) GP last seen & 3) Duty Doctor in more urgent cases. (SD)

2.13.6 Following the RCA Process

Communication

- **Devon Doctors**
 - Devon Doctors Call operator could have given clarity in that the GP was currently committed with a patient but that having spoken to the base receptionist the advise was that S's parents could take S straight to the treatment centre.
 - Devon Doctors call operator did not document that he had upgraded the call to urgent and that S was presenting following vomiting black liquid, though he had passed it verbally to base.
 - More effective communication from the receptionist with the parents on their arrival at Newton

Abbot Treatment Centre in relation to letting the doctor know they had arrived would not have left the family feeling that they had been 'placed at the back of the queue'

- Communication regarding the RCA Process

- The NPSA Being Open Framework recommends the best practice for clinicians are the key point of contact.
- In this situation closer liaison, regarding the different aspects of the varying parts of the investigation, would have identified all agencies involved at an earlier stage and lessened the degree of confusion and improved the experience for S's parents.
- S's father noted that he would have appreciated contact by the RCA chair so he and his wife would have known exactly what was happening in relation to the investigations.
- Please note that where a child death is part of the rapid response process the co-ordination is part of the process along with close review of preceding events with the family, which helps identify agencies involved. S's father noted that he would have appreciated contact by the RCA chair as he and his wife knew exactly what was happening in relation to the investigations.
- The Surgery was "not aware of their role" after S's death: There is an unwritten system that the Surgery has always operated whereby the GP of the patient (or

their next of kin) is responsible for getting in touch as soon as is reasonable, either by phone or visit. In this instance, direct contact was complicated in the early few days because calls were answered by S's Grandmother and messages were passed on. The dilemma was whether offering support via the Grandparent was sufficient or whether the Surgery should have been more proactive with the possible risk of interfering. A lot of time was spent in discussion amongst the doctors and staff about care and support but the lack of personal contact came across as if there was a lack of interest from the Doctors. All of the practice staff feel extremely sorry that the family felt neglected — the reality could not have been further from the truth. Having discussed this issue it was realised that, as direct personal contact was not made in the early days, a card with condolences could have been written and posted. A card for this purpose has been specifically chosen. (SD)

2.14 Arrangements for Shared Learning

All organisations are to disseminate the learning across their organisations.

NHS Devon will disseminate the learning to other commissioners and providers of Minor Injury Services within the region

NHS Direct will arrange for learning to be shared across their call centres

Devon Doctors will arrange for learning to be shared with all practitioners and appropriate staff

The South West Strategic Health Authority will arrange for dissemination through their learning networks.

NHS South East — Commissioners of NHS Direct

2.15 Distribution List

NHS Devon: Serious Incidents Requiring Investigation Panel and Executive Team,

Southwest Strategic Health Authority,

Torbay and Southern Devon Care Trust:
Director of Nursing

Northern Devon Healthcare Trust:
Director of Nursing

Devon Doctors: Board

Southwest Strategic Health Authority
Serious Incident Review Group

NHS South East

NHS Direct Board

[Name] Patient Safety and Quality
Manager (Commissioning) NHS Devon

10/06/2011

Serious Incident 2010/18615 Action Plan

Issue Raised	Action Planned	Action So Far	RAG	Action By	Due by	Update	Evidence of completion
Multi-agency investigations of child deaths that do not need a Rapid Response Process should be coordinated by secondary care as all child deaths are confirmed by a paediatrician who have a full history of the child's illness and agencies involved in their care. This will ensure that parents are kept informed and have one identified point of contact who will know exactly what is happening and will facilitate the investigative process.	Discussion with the Child Death Review Process Professional Lead			(Patient Safety and Quality Manager NHS Devon)	31/5/11		Review of Child Death Process
Where there is a complex multi-agency RCA or a Serious	Update relevant standard operating procedures in NHS Devon Incident			(Patient Safety and Quality Manager NHS Devon)	30/09/2011		Updated Incident Reporting Policy
Incident combining more than one process it may be appropriate for the Chair of the RCA to jointly undertake the role of Being Open lead with the Clinician in order to explain the different processes in place and how they work together.	Reporting Policy to include consideration of joint contact with patients / relatives following a Serious Incident requiring Investigation that requires a complex multi-agency RCA.						
	Prior to updating the Incident Reporting Policy learning to be shared with potential chairs of such meetings			Patient Safety and Quality Manager NHS Devon)	31/05/2011		No concerns raised in RCAs regarding the arrangements of the RCA

Issue Raised	Action Planned	Action So Far	RAG	Action By	Due by	Update	Evidence of completion
The practice completes the process of changing the message on the Touch Screen to include waiting times.	Complete the process of changing the Touch screen message			The lead GP	305/05/2011	Done	Changed Touch Screen Message
The practice completes the process of amending the information on the Amscreen information display to include waiting times.	Complete the process of amending the AMSCREEN information display			The lead GP	31/7/2011		Changed Amscreen wall message
The practice continue to provide patients with more directive information about what to do in the event of a deterioration of a febrile child and other patients who may need to contact Devon Doctors and to provide the Out-of-Hours number rather than directing them to listen to the answer-phone message.	GPs to provide more directive information regarding the deterioration of a febrile child to patients	Completed and Ongoing		The lead GP	Immediately	Done The Surgery have designed such a card with "warning signs & symptoms" on the reverse. As part of the "safety netting" process of informing patients how to recognise when a condition deteriorates and seek help, it is also necessary to suggest a reasonable time-frame for review if there are continuing concerns. The Doctors have discussed the use of Adastra (the information website for Devon Doctors On-call whereby clinical information can be shared) and they will continue to improve their liaison with the OOH services through this facility.	Review of patient surveys, and significant events
	To provide the Out of Hours number directly	Completed and Ongoing		The lead GP	Immediately		Review of patient surveys, and significant events

Issue Raised	Action Planned	Action So Far	RAG	Action By	Due by	Update	Evidence of completion
The practice continues to review children's nappies in relation to being used an indicator for dehydration even though there may be not other indicators	Clinicians in the practice routinely review nappies as an indicator for dehydration, even though other clinical symptoms may not indicate a need to do so	Completed and Ongoing		The lead GP	Immediately	Done	Review of Significant Events
NHS Direct review the incident in relation to the aspects identified by the RCA as requiring clarification.	Regional Clinical Governance Lead of NHS Direct to be informed of recommendation	Complete		(Patient Safety and Quality Manager NHS Devon)	As soon as Possible	13/5/11 Action Complete	Verbal request followed by Email to NHS Direct
Devon Doctors review the escalation process for call handlers.	Head of Clinical Governance to review the escalation procedures for call handlers	Complete		Head of Governance Devon Doctors	31/5/11	22/05/11	Process on intranet
Devon Doctors to review suggested answer phone message for surgeries	Head of Governance to review	Complete in that reviewed — however, following discussion at Performance Monitoring / Commissioner meeting reviewed again to include message re pharmacies. Details yet to be cascaded to practices		Head of Governance Devon Doctors	07/06/11		
Communication to and from non clinical staff (additional action following RCA)	Devon Doctors to review and re-train all non clinical staff in relation to call backs, emergency activations and communication with patients.			Director of Corporate Services, Devon Doctors			

Issue Raised	Action Planned	Action So Far	RAG	Action By	Due by	Update	Evidence of completion
The commissioners of the MIUs are aware of this incident as a positive example of the two organisations working together.	NHS Devon commissioners to be aware of this incident as a positive example — verbal update to be followed by copy of the report			(Non Medical Consultant Emergency and Unscheduled Care Torbay and South Devon Care Trust)	30/4/11		
NHS Devon and SDHT liaise to regarding identification of suitable bereavement support services for children.	Joint working by SDHT and NHSD to identify suitable bereavement support services in South Devon			Head of Governance NHS Devon and Clinical Governance Lead Children's Service SDHT	30/6/2011		

Annex F: Independent Review of the Investigation into the Death of Samuel Morrish (aged 3 years and 8 months)

Review Commissioned by:
[Chief Executive]
[Name of] NHS Trust

Review Conducted by:
[Director of Nursing and Patient Care]
And [a
Consultant Paediatrician]

Statements from Mr & Mrs Morrish

People reading this report and these statements should be aware that these were made at a point in time after the second investigation; they were not designed to be a definitive and final statement from Samuel's parents.

The family would wish to make it clear that these statements do not prejudice any further investigation and may be subject to change and further reflection following the further planned investigation into the circumstances of Samuel's death and the subsequent investigations.

It is important that people reading this report recognise that a full & complete response cannot be provided by Scott and Susanna Morrish until all issues have been thoroughly investigated and concluded and as such their thoughts and reflections may develop and change as further information or learning comes to light.

Narrative Account of Sam's last 2 days

Submission by Scott and Susanna Morrish, Sam's parents.

The week before Christmas, when it seemed the whole of the UK was frozen, my husband Scott, and my two boys caught Flu B. As always Sam got it worse than everyone else. For several days I was struggling to control his temperature, which would shoot up to 39.5 with alarming regularity. I embarked on a regular routine of dishing out Calpol and Ibuprofen, which would mean that despite his illness, he would perk up for a hour or so throughout the day, play with Lego, watch a DVD, or play rough and tumble with his big brother.

Sam's brother started to get better, but Sam appeared more poorly and had a really vicious cough. On the Monday night Sam was violently sick twice, so I made an appointment to see the GP. I was concerned that Sam may have developed a chest infection - his history showed that he never got a nasty cold / cough that didn't turn into an infection. As far as I was concerned it was just a matter of time before this happened. Sam had also been complaining of a lot of tummy pain, which I thought might have been caused by his persistent cough.

The duty doctor who examined Sam said there was no sign of a chest infection. He was a 'very poorly boy' but it was just the same virus that everyone else had at that time. He did give us a prescription for anti-biotics, 'just-in-case' it did turn into a chest infection, but he explained that there was no need to give them at the moment. They were basically prescribed because of the icy weather and the proximity to Christmas. We accepted this. Although Sam was very poorly, he was still behaving within our understanding and experience of 'how Sam was' when he was ill. I didn't want to give him anti-biotics if they were unnecessary,

although I didn't feel entirely confident about how to determine when they would become necessary, as his chesty cough already sounded pretty bad to me.

Wednesday 22 December — Morning

Although Sam slept better the following night, shortly after he woke in the morning I started to feel something was wrong. He only ate 2 teaspoons of breakfast and was still complaining of tummy pain. But more than that he just looked so ill. He had no colour at all, was very pale and had no interest in anything. I gave him doses of calpol/ ibuprofen expecting him to have a little 'brighter' patch as the medicine kicked in, as normally happened in these circumstances. But 'normal' didn't happen. He just lay on the sofa with Scott, drifting in and out of sleep, not interested in what his brother was playing, not interested in a DVD... just really thirsty: He wouldn't put his drink down.

Unusually, I decided it was best to keep Sam in a nappy, as he was sleeping so much, to avoid accidents. I decided to call the surgery again. I explained that the doctor who had seen Sam the day before had described him as a 'very poorly boy', but that Sam seemed so much worse today. It was odd because Sam's very high temperature had settled down to 37.5, but 'he seemed so much more ill'. It was like he was 'here but not here'. He wasn't interested in anything and was just drifting in and out of sleep. A couple of hours later, when the duty doctor phoned back. an appointment was made to bring Sam into the surgery for 4pm that afternoon.

Wednesday 22 December — Afternoon

As we waited in the surgery I started to get increasingly anxious about Sam. I felt tearful and exhausted, having no idea how long we would need to wait to be seen, and not knowing what to do. Sam was asleep on my lap,

but he woke up when we were called. I tried to explain the dramatic change in him over the last 24 hours, the symptoms of 'here but not here', that he wasn't interested in anything, that he was really thirsty, that he had tummy pain, and a never-ending hacking-cough. It also seemed really odd that his temperature had gone down - yet Sam just 'looked so much more ill'. The Dr asked if he was weeing OK. I responded that 'he'd been in a nappy all day'. I was trying to explain that he was too ill for me to expect him to go to the toilet, even though he had been potty trained for over a year. The nappy wasn't checked to see if he had been weeing or not. We were sent home with a prescription for some cough syrup. But I didn't know who to ring, or what to do if Sam's condition deteriorated later in the day. I did not feel reassured. I felt deeply worried, and discussed this with Scott in the car as we drove home. Scott felt that if the GP had sent Sam home, then we didn't need to worry... Sam would be okay. I felt that the Doctor had been in two minds, and had just come down on the side of 'the best place for Sam is to be at home'.

Wednesday 22 December— Evening

Sam wouldn't eat any tea - but was still very thirsty and continually sipping his water. At about 6pm he was sitting on my lap, and said again that his tummy was hurting, and then he was sick into a bowl. I thought it didn't look right: there were tiny black streaks in the clear liquid, which looked to me like they could have been blood. I felt worried so I phoned the surgery. It was closed, so I phoned NHS direct, (they had been helpful to us in the past - so I felt confident that they would know what to do). The nurse asked several questions which included asking us to check Sam's Nappy. It was completely dry. It was at this moment that we realised that Sam hadn't weed since 10am. The NHS direct Nurse seemed very concerned about this, more so than about the vomit. She

said that someone would call us back. What we didn't know at the time, was that she had recorded some of the answers I gave to her questions incorrectly on her computer, and failed to ask other important questions. We did not know that part of the NHS Direct algorithm she was using was wrong, and that as a result of all of these things, the call was wrongly classified as 'routine' - when it should have been an 'emergency'.

Sam went to bed and instantly fell asleep. About an hour later, whilst I was getting Sam's brother out of the bath, the phone rang but it cut off when I picked it up. I rang 1471. The number was with-held. I didn't have a name or a contact number for the Doctor who was going to call me back. However we thought that, as they know it's serious, IF it was the Doctor, then he or she would try again in a minute: if it wasn't the Doctor, we needed to keep the landline clear.

By 8.30 there had been no other call. I was really anxious for Sam and eventually found a number for the Out of Hours doctors on the internet (we had never used this service before). I was told someone would call back in the next 10-15 minutes.

After this it's a blur. Scott went upstairs to check Sam. I remembering him calling to me, 'Sam has just been sick again' and 'this time it's all black', and seeing Sam covered in a thick black-sticky-liquid. I remember thinking 'doesn't this mean internal bleeding? This is really bad'. I knew he need to go somewhere... and fast... but I didn't know what the right thing to do was, so I phoned the Out of Hours Doctors number again - thinking they will know what we need to do for Sam. This time I was put through to a different person.

I explained that my three year old son had just vomited black liquid and asked 'shouldn't I be taking him somewhere quickly'. When it was suggested that I want to go to the local

hospital I responded, 'IF they've got suitable treatment' and the person on the phone assured me that he would work out the best place to take Sam.

When he phoned back, we were told to go to the local hospital. He said 'they have the same facilities as Torquay, and if we go to Torquay they might just send us back to Newton Abbot Treatment Centre anyway'. He also said that he would adjust the case details and let Newton Abbot know that we were bringing Sam to them. This was about 21.20. What we didn't know was that neither the person I spoke to, nor the person he subsequently 'consulted' about the action we should take for Sam, had any medical qualifications at all. The advice they gave us was based on a conversation between a call handler and a driver. Neither of them had any medical training. Their advice was not based on the severity of his symptoms: it was based on geography. We had no idea about this at the time. We thought the advice that we duly followed was coming from a GP. Newton Abbot Hospital does not have all the same facilities as Torquay. No one suggested we should call 999.

We arrived at Newton Abbot Hospital just after 9.30. Scott carried Sam in his arms. I'd never seen Sam look so ill and so pale before. We went to the reception desk, and I explained this is Sam Morrish, you should be expecting us. The receptionist says, yes, we've got you on the system - please take a seat, there are three people in front of you. I hesitate. I'm exhausted, afraid and confused. We sit down. I don't understand.... they know that he's vomiting black liquid.... they know he hasn't weed for 12 hours.... I've discussed on the phone 'shouldn't I be taking him someone really fast' and the person I had spoken to agreed.... so why are we being told to wait? Is it not that serious after all? ... have the other three children waiting here also been vomiting up black liquid? I'm not a medical person. I

trusted the judgement of people I have spoken to - people who I believed were medical staff.

The anxiety is overwhelming. Sam is hacking away with his cough as we sit and wait. I can't see any doctors or nurses. I have a cloth ready in my hand in case he starts to vomit again. We still haven't been seen - in fact no-one has left the queue at all. Our mobile rings. Scott steps outside to deal with it. Alone in the waiting room I am almost in tears when suddenly a Minor Injuries Unit nurse walks by. It is now about 9.55. I call out, 'Please- can you help me'. She takes one look at Sam and rushes us into side room. Please be clear about this. The only reason we were seen when we were, was because I asked for help.

Suddenly the doctor is there.

Then paramedics.

And then we are in an ambulance being rushed to A&E.

Shortly after arriving at A&E Sam had an Xray of his chest. We explained to one of the registrars that Sam had been seen by a GP at 4.30pm and that he had been sent home, and that the doctor who had examined Sam had said his lungs were clear. Yet 5 hours later this X-ray showed that one lung was completely full/ white. It seemed as if A&E simply assumed the GP had been wrong, rather than thinking if Sam's lungs were clear at 4.30pm, how quickly is his condition deteriorating? ... and what could cause Sam to deteriorate so fast? ... and what had caused the blood in Sam's vomit? The assumption seemed to be that the GP had made a mistake, 'what was the GP thinking of sending us home?'.

Despite these concerns, we felt reassured that Sam was now in the right place, after all of the waiting, and that he was now getting the treatment that he needed. He was surrounded by people who knew what to do. Scott noted that we might still be here for Christmas - and

the nurse beside us said comfortingly - don't worry we'll have him home by Christmas.

Eventually they decided to transfer Sam to the High Dependency Unit - rather than to Intensive Care. All we knew was that the description of the High Dependency Unit sounded more friendly - and less intimidating - and we did not want Sam to be scared.

Thursday 23 December

After Sam's transfer to HDU, Scott went home to get sleep so he could look after Sam's brother the next day. We thought Sam was stable. We thought he'd be OK now. We just thought we all needed to try to sleep. We didn't know that the hospital had failed to give Sam the anti-biotics he desperately needed for 3 hours after they prescribed them. We had no idea how sick Sam was or that there was such a thing as septicaemia. We didn't know that the Flu had weakened Sam so much that it had allowed an invasive bacterial Strep A infection into his blood. We had never heard of that either.

Shortly after Scott got home at about 1am, I called him back to the hospital. Shortly after that Sam slipped into a coma.

By 5.00 am on the 23rd December, surrounded by doctors, Samuel died from Septic Shock.

23 December

Mixed in with the overwhelming shock and grief we felt when Sam died was total confusion.

We had so many questions.

There was no air.

Just disbelief and complete confusion.

What on earth had happened?

How could our little boy die?

What could do this?

Why did the GP send us home?

Why didn't NHS Direct seem concerned about the blood in his vomit?

Why were we sent to Newton Abbot by Devon Doctors when Sam's condition was clearly deteriorating... and why, why, why were we made to sit and wait in a queue once we got there?

We were told that there was no need for a coroner to be involved.

After 23 December

Later... we started to ask questions. We tried to understand something about what had happened to Sam. We were told that there would be an investigation into what had happened to Sam, but that it would be confidential. We would never see it. Then after lots and lots of questions and contradictory answers, we were told there would be an investigation which we would see eventually. We asked questions. We offered information. Everybody was sympathetic. No one really told us anything. Even simple questions remained unanswered. No one asked us anything at all. More confusion. We were there. We know whom we spoke to and what happened. How can they write a report without speaking to us?

I tried to write a brief document to outline our experience, expressing the opinion that Sam's care was delayed by every organisation he came into contact with. (At that stage we weren't aware of the full extent of the delay in administration of anti-biotics.) However when the draft of the RCA report came out my comments were completely dismissed. Furthermore none of the questions we had been asking had been addressed. Whole chunks of information were missing or inaccurate, nobody seemed to be asking any probing questions at all - let alone trying to find areas for 'learning'. The report was ill-informed, misleading and pointless. In places it was fictional.

As a result we spent months in meetings, making phone calls, and emailing the various organisations involved - trying to get answers - trying to show the NHS the missing pieces of the picture. On top of our grief this was overwhelmingly stressful. We had to keep going back over the most painful 24 hours of our lives. I can't describe what it feels like to listen to the voice recordings from that night. If anyone else had listened to these recordings - they could have answered some of our questions.

Despite all our efforts to get NHS organisations to examine what had gone wrong for Sam, we felt the NHS was not listening to us.

It was not interested in anything we thought, or had to say

We felt that they were deliberately not addressing difficult questions, that they were blame-shifting, and basically hoping for us to just give up and go away.

The NHS failed repeatedly, in lots of different ways, and then on top of that the NHS failed to investigate anything in any meaningful way.

We will never know if Sam would have lived, if the NHS had functioned in the way that it should.

But we do know that Sam was let down by each organisation we turned to for help. In a 'race against time' Sam was not given the chances he needed to survive.

Preface

'The effects of harming a patient can be widespread. Patient safety incidents can have devastating emotional and physical consequences for patients, their families and carers, and can be distressing for the professionals involved.'

Being open about what happened and discussing patient safety incidents promptly, fully and compassionately can help patients and professionals to cope better with the after effects.'

'Being Open'
(Saying sorry when things go wrong)
National Patient Safety Agency, 2009

Samuel Morrish (Sam) was aged 3 years and 8 months when he died at Torbay Hospital, two days before Christmas 2010.

This report looks at the events leading up to Sam's tragic death and contains testimony from his parents, Scott and Susannah Morrish. It also looks closely at the investigations carried out by the NHS organisations involved in Sam's care following his death.

Nothing that is said or is written can change the devastating impact that Sam's death has had on his family. Scott and Susannah have lost a cherished son and Sam's brother has lost his little brother.

In agreeing to undertake this review. I gave Scott and Susannah a commitment that I would seek to ensure three things:

- That their voices, as loving parents, was heard
- That an accurate picture of the circumstances and events leading-up to Sam's death was recorded, any deficiencies in care recognised and that action would be taken to address such deficiencies

- That action would be taken to ensure that the 'Being Open' guidance is fully implemented by our local NHS, as a means of learning.

Throughout the process, I endeavoured to imagine myself as a parent who had lost a 3 year old child and to consider whether the questions I would have had, in those awful circumstances, had been answered. Sadly, in many cases, they were not.

I am confident that this report contains an accurate picture of the circumstances leading up to Sam's death; the cause of his death and the confounding factors - which may have had an impact upon the ultimate outcome for Sam.

I am equally confident that the process of the review has served to highlight the key clinical issues that need to be learned from and addressed. The review demonstrates the importance of ensuring thorough, open and co-ordinated investigation processes that involve the families for whom care has 'gone wrong'.

And, finally, the review highlights the terrible impact that can be caused, to an already traumatised family, by a failure to respond quickly, thoroughly and openly.

The health and social care system in Devon and Torbay has a great deal to learn from Sam's death and about the inadequate processes of investigation which followed. I am encouraged however, having recognised and acknowledged previous inadequacies, by the willingness of everyone concerned to engage in this process and the commitment to learn from it.

I would like, in particular, to pay tribute to the Morrish family for their patience, tolerance and relentless efforts to ensure that Sam did not die in vain. Scott and Susannah, despite their devastating loss and bewilderment at the first investigation into Sam's death, have

fully engaged in this review. They are to be commended for their honesty and integrity and the willingness they have shown in sharing what has been an unimaginably traumatic experience for them.

On behalf of the local NHS I would like to apologise for the deficiencies in the care that Sam received. Based on the content of this report, and on the commitments made by each of the organisations concerned, I would also like to provide reassurance that action will be taken to address what went wrong.

The shortcomings of the first investigations into Sam’s death are manifestly evident and acknowledged by all of the organisations concerned. I am now satisfied that an altogether more thorough and open review has taken place and that the necessary action will be taken to minimise the likelihood of anything similar happening again.

As a fitting response to this report, I am recommending that it is shared as part of a conference on ‘Being Open’. This will be held here in the Peninsula, sponsored by Medical and Nursing Directors from all of our local NHS organisations and attended by clinicians and managers working across local health and social care services. The objective will be to take the learning from this, and other, serious incidents and to promote a more open, engaging and learning culture.

My thanks to Scott and Susannah Morrish, [the Director of Nursing and Patient Care and the Consultant Paediatrician who conducted the review] for their commitment and support in producing this report and for helping to deliver the improvements that will be made as a result of it.

Background to the review

In June 2011, the Head of Governance at NHS Devon asked the chief executive of a nearby trust to consider the case of Samuel Morrish (Sam). He was informed that the following organisations were involved in Sam’s care:

Cricketfield Surgery, Newton Abbot

Devon Doctors On-call

NHS Direct

South Devon Healthcare NHS Foundation Trust (Torbay Hospital)

NHS Devon.

Each of these organisations had completed their own investigations following Sam’s death. A Root Cause Analysis (RCA) had also been carried out and a report produced.

It was clear that there was considerable dissonance between organisations regarding Sam’s care and the events leading-up to his death. Sam’s parents had also expressed concerns about the processes that had been followed and the lack of accuracy in the RCA report — which, they felt, did not concur with what they had experienced.

The chief executive agreed to review the investigation reports, the RCA report and the recordings of telephone conversations in relation to Sam’s case. He then met with Sam’s parents. This meeting was hugely informative and instrumental in his decision to commission an independent review of the case.

The chief executive then met with all of the organisations concerned. On behalf of the Morrish family, he conveyed his disappointment at the quality and transparency of the investigations that had taken place up until that point and the lack of involvement of Sam’s parents in the investigation process. He confirmed that he would be commissioning

an independent review of the case and was reassured by the willingness and commitment displayed by all of the organisations to participate in this review.

The chief executive then commissioned the Director of Nursing and Patient Care, and a Consultant Paediatrician, both of a nearby trust, to undertake a review in accordance with the Terms of Reference set out in this report.

Objectives of the review

The objectives of the review were to:

- 1. Ensure that the clinical circumstances leading-up to Sam’s death are recorded accurately and fully understood by the organisations involved
- 2. Ensure that Sam’s parents have the opportunity to give their account of what happened
- 3. Ensure that any deficiencies and/or failings in care are recognised
- 4. Ensure that clear learning has occurred and where appropriate, action is taken to minimise the likelihood of anything similar happening again
- 5. Consider the investigations carried out by the organisations in the context of ‘Being Open’
- 6. Address the inadequacies of the previous investigations and to ensure that improvements occur
- 7. Share the learning from this tragic case across the wider NHS, with a view to improving clinical practice
- 8. Highlight the importance of applying the ‘Being Open’ framework following traumatic incidents such as Sam’s death
- 9. Highlight the need for the strong co-ordination of investigation processes

between and across organisations to ensure learning and improvement across whole systems of care.

The report has three key elements to it:

- An account by Scott and Susannah Morrish of their experience
- A report that sets out the findings of the independent review
- A series of responses and proposed actions from the organisations involved in Sam’s care.

1. Terms of reference

Following the death of Master Samuel (Sam) Morrish (date of birth 11/04/2007, date of death 23/12/2010) an investigation review is commissioned by the chief executive of a nearby trust, acting as independent chair of the investigation process. The review will:

- Listen to the views and opinions of the parents

- Span the 'whole system' taking into account the issues and findings within individual organisations

- Review the organisational reports/ reviews undertaken to date

- Synthesise the findings from the individual organisational reports and identify emergent themes

- Apply professional clinical judgement regarding the chronology of events and the possible clinical consequences

- Seek to identify the root cause

- Seek to identify contributory factors

- Identify opportunities for learning through the identification of both good practice and any shortcomings

- Propose actions that when implemented may minimise the risk of any shortcomings being repeated in the future

The review will be undertaken by:

- The Director of Nursing and Patient Care at a local trust (Timeline, Family Care Review and Investigation Review)

- A Consultant Paediatrician at a local trust (Clinical Case Review)

Organisations involved are:

- NHS Direct — CEO

- NHS Devon — Executive Nurse

- GP — Cricketfield Practice, Newton Abbot

- Devon Doctors — CEO

- South Devon NHS Foundation Trust — Director of Nursing

A report will be produced and submitted to the chief executive of a local trust (acting as independent chair of this process) by 31/08/2011.

2. Review process

The review process comprised four main elements —

- A clinical case review

- The production of a timeline or chronology spanning Sam's journey from initial GP consultation to his death; reflecting Sam's care across organisational boundaries. The timeline also extends beyond Sam's death to reflect the period immediately following, in order to encompass family support and bereavement care.

- A review of the care and support offered and provided to the family following Sam's death

- A review of the multi-agency investigation undertaken following Sam's death

Central to the review process has been engagement and liaison with Sam's parents. Listening to their experience, views and opinions has prompted specific unanswered questions to be asked. The agencies involved have been asked questions from Mr and Mrs Morrish and the reviewers. The review process and resultant report seeks to provide answers to those questions, whilst also outlining learning that individual organisations, and indeed the local NHS system, has gained as a result of analysis into Sam's care. Recommendations conclude the report.

The report was finalised following a meeting with Mr and Mrs Morrish, in the presence of [the Director of Nursing and Patient Care and the Consultant Paediatrician who conducted the review] on 30.8.2011.

2.1 The clinical case review

The clinical review is based upon reviewing written and e-mail evidence, including the Root Cause Analysis (RCA version 7, 24.6.11) and listening to the audiotapes of telephone conversations. The reviewer has also met with [the lead GP and First and Second GPs] and has spoken to the consultant paediatrician over the phone.

This review is set out chronologically, interspersed with comments, with clinical opinion at the end. All statements are as originally written, apart from the First GP's account where he erroneously called Samuel's brother Daniel. This has previously been acknowledged and has been changed for the purpose of this review.

2.2 Timeline/chronology,

The production of a timeline or chronology is considered a key tool in undertaking an incident investigation. The aim is to allow a 'standing back' in order that parties can digest the incident or events as a continuum.

(Dineen 2002].

The timeline presented at Annex A identifies the data sources from which the event information has been obtained. In addition, it outlines any data gaps, acknowledgement of shortcomings, notable practice, service based questions and remaining unanswered questions from the family's perspective, following the previous RCA investigation. As answers have been gathered from the respective organisations, the reviewers have taken account of the responses in producing the final report, in particular bringing clarity to the clinical case review and informing the recommendations.

2.3 The family care review

Central to this element of the review is the experience of the Morrish family. The narrative provided by Mrs Morrish and time spent with Mr and Mrs Morrish provided the reviewer with first hand testimony from the parents’ perspective in relation to thoughts and feelings experienced by the family in the period immediately after Sam’s death up to the present day.

Copies of correspondence between the parents and the various organisations were also provided and analysed. National guidance provides a reference point when considering how improvements can be made to systems that have fallen short in terms of meeting family need or best practice. The central document used in this review was “Working Together to Safeguard Children — A guide to inter-agency working to safeguard and promote the welfare of children”
(HM Government March 2010).

2.4 Investigation review

Analysis of the various reports produced as a result of the investigation into Sam’s death, coupled with consideration of national guidance in relation to undertaking investigations within the NHS, have been the basis of this element of the review process. In addition, first hand testimony from Mr and Mrs Morrish has enabled the reviewers to identify shortcomings and propose actions that can be taken to improve the care of others.

3. Clinical case review

3.1 Introduction

I am [Consultant Paediatrician’s name] and I work as a Consultant Paediatrician at the [a nearby trust]. I am fully registered with the GMC and have been a consultant for seven years.

Samuel Morrish sadly died on the 23 December 2010 from influenza complicated by invasive Group A streptococcal disease.

3.2 Chronology

3.2.1 Susanna Morrish¹

“The week before Christmas when it seemed all of the UK was frozen, everyone in the house (apart from me) caught flu. We now know this was Flu B. Mostly it appeared like a very nasty cold but as always Sam got it worse than everyone else. For several days I was struggling to control his temperature which would shoot up to 39.5 with alarming regularity. I embarked on a regular routine of dishing out Calpol and Ibuprofen, which would mean that despite his illness, he would perk up for a hour or so throughout the day, play with Lego, watch a DVD or play rough and tumble with his brother — one such incident ending up with one of Sam’s big nosebleeds. After a couple of days of Sam being ill, his big brother was getting better, but Sam was definitely getting more poorly and had a really nasty sounding cough, it would stop him sleeping and he was waking up a lot in the night coming to find me. (As Scott was also ill he was sleeping downstairs). On the Monday Sam was violently sick twice in the night and I thought it was time to take him to the

GP. We made an appointment for Sam’s brother, Scott and Sam all to see the duty doctor. I was concerned that Sam may have developed a chest infection — his history showed that he never got a nasty cold/cough that didn’t turn into an infection and he would also get very wheezy. As far as I was concerned it was just a matter of time before this happened...Sam had also been complaining of a lot of tummy pain which I thought may be down to the really persistent, never ending cough.”

3.2.2 The First GP²

Tuesday 21 December 2010 — morning consultation

“It was the first time I had met Mr and Mrs Morrish, Sam’s brother and Samuel. It was a joint consultation of Samuel and Mr Morrish as they had been very unwell for about one week up until they came to see me. Mr and Mrs Morrish informed me that Sam’s brother has been unwell previously with similar illnesses prior to his father and brother coming down with similar symptoms, but had been able to overcome it after a while. As I recall his illness was characterized by high fever and a cough. I recall consulting about Samuel first. His parents informed me they were concerned about his fever, cough, rash on his body and vomiting. On discussion I got from the history that the rash was fairly new, his fever was very high at times and that the vomiting (although at time random), was mainly after a spell of coughing. He had been unwell for about one week.

I recall that Samuel was alert and friendly, slightly subdued and allowed me to examine him easily. He had a fine red rash on his trunk. This was able

to be reduced with gentle pressure to the skin which was reassuring. His colour was good and his hands were well perfused (his circulation to his hands looked normal). I listened with my stethoscope to his back and chest. I heard he was taking air equally to both sides of his lungs and there were no obvious crackles or abnormal noises that normally go hand in hand with a pneumonia-type infection. His breathing pattern seemed comfortable at that time. He didn’t look like he was working hard or battling to breathe at that time. We discussed his eating and drinking in the context of his vomiting and it seemed that he was managing a good fluid intake although his food intake was slightly reduced. It seemed to me that he had a flu-like illness.

Due to the nature of Samuel’s symptoms and the proximity in time to Christmas, I felt that if he were to develop symptoms suggestive of pneumonia, that I would be able to help him by prescribing a “delayed script” of amoxicillin antibiotic medication. My advice at the time as I recall is that if his symptoms were to worsen that Mr and Mrs Morrish could use the antibiotic. We discussed his probable diagnosis of flu (and possible swine flu) and the role antibiotics play in this regard.”

3.2.3 Mrs Morrish was giving Samuel alternate doses of paracetamol and ibuprofen. During the consultation, Mrs Morrish remembers asking about the dose of ibuprofen and the fact it was being given on an empty stomach. She remembers [the First GP] reassuring her that it was OK.

3.2.4 [The First GP] also examined Sam’s brother and Mr Morrish. Examination of Sam’s brother was unremarkable.

Mr Morrish's examination was similar to Samuel's except for the rash. He had chest wall pain with his coughing. Mr Morrish's story and examination seemed to point to a diagnosis of flu as well. [The First GP] discussed ways to alleviate Mr Morrish's symptoms and discussed seasonal flu vaccination.

3.2.5 Samuel's past medical history

Samuel was seen in A&E in November 2009 following a referral by his GP, with cough, fever and abdominal pain. A chest X-ray was interpreted as showing left lower lobe changes and Samuel was prescribed a 3 day course of Azithromycin. He was followed up in outpatients on 16.11.09 and clinically was much improved³. The chest X-ray was subsequently reviewed by a radiologist who felt it was clear.

Samuel was seen several times at the GP surgery mainly by the nurse practitioner for episodes of wheeze associated with upper respiratory tract infections. He never developed chronic asthma symptoms and did not require regular inhaler therapy.

3.2.6 Susanna Morrish¹

"When the duty doctor [the First GP] saw Sam and examined him he said here was no sign of chest infection. He was a "very poorly boy" but it was the same virus that everyone else had at the moment. However, as it was nearly Christmas he'd give us a prescription for antibiotics, just in case it did turn into a chest infection, but there was no need for them at the moment. I accepted this as, although Sam was, in my eyes, very poorly with his cold, he was still behaving within my understanding and experience of how he was when he was

ill. I didn't want to give him antibiotics if they were unnecessary, although I didn't feel entirely confident as to how I should determine when they would become necessary, as his chesty cough already sounded pretty bad to me."

3.2.7 Following Samuel's death, [the First GP and the lead GP] reviewed the management of Samuel's case in the light of guidance issued by the Department of Health and Health Protection Agency regarding the clinical management of patients with an influenza-like illness during an influenza pandemic. In addition to reviewing local guidance policy and national advice from the Chief Medical Officer, the lead GP also contacted the Communicable Disease Department at Dartington. On discovering a Group A streptococcal pathogen, Sam's brother and Mr Morrish were prescribed prophylactic antibiotics and seasonal flu vaccinations for the family organised.

3.3 Comments

3.3.1 I met with [the First GP and the lead GP] on 22nd August 2010. We discussed the chronology of events, reviewed [the First GP]'s consultation, Samuel's subsequent medical care and his post mortem results.

3.3.2 [The First GP]'s examination concludes with a diagnosis of an uncomplicated flu-like illness with no signs of circulatory compromise or pneumonia. Mr and Mrs Morrish felt reassured following their consultation with him. With Christmas several days away, [the First GP] prescribed a delayed script of antibiotics in case Samuel's symptoms worsened. Although he does not remember what specific advice he gave, his normal practice is to recommend

starting antibiotics at home if a child's respiratory rate increases and there are signs of respiratory distress i.e. signs of a developing chest infection. Mr and Mrs Morrish remember that the antibiotics were given to them 'just in case his breathing gets worse' but with no further specific instruction. Mrs Morrish found this unhelpful as she already thought Samuel breathing was 'pretty bad'.

3.3.3 Delayed prescription of antibiotics

Children who present with uncomplicated flu-like symptoms to their GP are not routinely prescribed antibiotics. Meta analysis of the evidence for antibiotic use in simple throat and/or ear infections has shown only modest benefits as most cases resolve spontaneously, a significant percentage having a viral cause. The benefit of antibiotic treatment has to be balanced against their adverse effects and the risk of bacterial resistance. The practice of issuing patients with a delayed prescription for antibiotics has become one method of managing such cases in secondary care.

3.3.4 Management of patients with an influenza-like illness during an influenza epidemic

Samuel presented to his GP with a flu-like illness during a seasonal flu epidemic. During 2009 and early 2010, the country had suffered from a swine flu (H1N1) pandemic. The Chief Medical Officer (CMO, Department of Health) issued guidance on how to manage suspected cases of swine flu⁶ and although Samuel subsequently was found to have influenza B and did

not present during the pandemic, an argument could be made that the CMO guidelines could have been used in this case.

The Chief Medical Officer issued this advice in October 2009 on how to manage adults and children presenting during the pandemic with a flu-like illness. In its introductory summary, the guidance warns of an incomplete evidence base and that clinical judgement must remain paramount.

Recommendations are made for primary care management. The first is regarding antiviral therapy (Oseltamivir). It is stated that in patients with seasonal influenza A infection, antiviral treatment was most effective if commenced as soon as possible and in any case within 48 hours of symptom onset (there was some evidence that suggested give it up to 7 days in hospitalised patients).

The guidance also gives advice on empiric antibiotic therapy. They state that patients do not routinely require antibiotics if they have uncomplicated influenza and were previously healthy, that children with complications of a lower respiratory tract infection, a severe sore throat or ear infection or severe painful cervical lymphadenopathy (enlarged neck glands) should be offered antibiotic therapy.

3.4 Chronology

3.4.1 Mrs Morrish wishes to state by the morning of Wednesday 22 December "everything changed". Samuel was much more ill, "not like Sam anymore" and his illness was now "out of her framework of understanding."

3.4.2 Susanna Morrish¹

Sam didn't wake up the following night and wasn't sick again, but shortly after he woke in the morning I started to feel something was wrong. He only ate 2 teaspoons of breakfast, and even throughout his days of feverishness and sickness I'd always managed to persuade him to eat something. (He was still complaining of tummy pain). But more than that he just looked so ill. He had no colour at all, was very pale and had no interest in anything. I gave out the normal dose of Calpol/ibuprofen and expected him to have a little "brighter" patch as the medicine kicked in, as would be normal. But normal didn't happen. He just lay on the sofa drifting in and out of sleep, not interested in what his brother was playing, not interested in a dvd ... just really thirsty. He wouldn't put his drink down.

About 10.00 I took him to the toilet where he did a tiny wee and I decided it was best to keep him in a nappy as he was sleeping so much. (Sam had been potty trained for well over a year, but still wasn't dry at night). It was around this time that I called the GP and got through to the Triage nurse. I explained that Sam had seen [the First GP] the day before and that the Dr had described him as a "very poorly boy" but that Sam seemed so much worse today. And it was odd because his very high temperature had settled down to around 37.5, but "he seemed so much more ill". It was like "he was here but not here" and "wasn't interested in anything" and "was just drifting in and out of sleep"

3.4.3 [The Second GP]

Wednesday 22 December 2010

"I was the Duty Doctor for the surgery on this day and on our list of triage appointments was a request to telephone Mrs Morrish regarding Samuel. The request had been place on the triage list at 10:45am. At 13:50 Mrs Morrish was telephoned by one of our nurse practitioners, who passed the call on to me and I telephoned Mrs Morrish at 14:00. Mrs Morrish explained that following their appointment with [the First GP] on 21.12.10, Samuel had deteriorated. Given that he had got worse and Mrs Morrish had ongoing concerns I encouraged Mrs Morrish to bring Samuel to the surgery and we agreed to an appointment with me at 16:10."

3.4.4 Susanna Morrish¹

"[The Second GP] called back and I again tried to explain that Sam seemed really poorly and that I was worried about him. I was also worried about getting out in the snow /ice with two sick children and a sick husband. An appointment was made to bring Sam into the surgery for 4 pm that afternoon.

We arrived at Cricketfield just before 4 pm and I sat waiting with Sam on my lap, with him half drifting in and out of sleep. Every now and again he would cough his hacking cough and take sips of water. After we had waited for 10 minutes I started to get increasingly anxious about Sam, I felt tearful and exhausted, having no idea how much longer we had to wait, not knowing what to do. When we were called, Sam was asleep, he woke up when I carried

him into the room. I tried to explain the dramatic change in him over the last 24 hrs, the symptoms of "here but not here", that he wasn't interested in anything, he was really thirsty, had tummy pain, a never ending hacking cough and he just "looked" so much more ill. It also seemed really odd that his temperature had gone down, yet obviously he appeared more ill. Sam was examined by the Dr who asked if he was weeing OK. I responded he's been in a nappy all day. I was trying to explain that he was too ill for me to expect him to go to the toilet, even though he had been potty trained for over a year. The nappy wasn't checked to see if he had been weeing or not. We were sent home with a prescription for some cough syrup. I didn't have any information about who to ring or what to do if he deteriorated later in the day."

3.4.5 [The Second GP]

"That afternoon, I met Samuel with his mother at 16:30. He was obviously unwell sitting on his mother's lap and not wanting to interact much during the consultation. However, on examination, his respiratory rate was normal, his chest was clear and his throat showed no obvious focus of infection. On discussion with Mrs Morrish, I was satisfied that she was managing to get Samuel to drink enough and he did not appear dehydrated. He had a blanching rash in keeping with a viral illness which had not progressed since being seen by [the First GP] that day before and was not the type of non-blanching rash associated with meningitis. Towards the end of the consultation, Samuel briefly chatted with us and was obviously aware of what was being said and did not appear confused or disorientated.

I felt that Samuel was still suffering from a flu-like illness with no current evidence of secondary bacterial infection and as a result advised Mrs Morrish to continue the supportive measures she was already doing, and I could not see any clear indication for starting antibiotics at this stage. Mrs Morrish agreed with this plan and we also discussed the need for a further medical review, either at this surgery or with the out of hours service, should Samuel's condition deteriorate."

- 3.4.6 Mrs Morrish remembers mentioning that "she had seen in the news that young children really ill with flu were being seen by their GP, told they've got a virus and then end up fighting for their life on ITU." Mrs Morrish remembers [the Second GP] stating "I think the best place for him is at home" and feeling not reassured by his decision.

3.5 Comments

- 3.5.1 I met with [the Second GP] on 11 August 2010. We discussed the chronology of events, reviewed the Second GP's consultation, Samuel's subsequent medical care and his post mortem results.
- 3.5.2 Mrs Morrish phoned the Cricketfield Surgery at 10.45 am. She received a telephone call from [nurse practitioner] at 13.50. [The Second GP] informed me telephone calls are attended to sequentially and the time taken to respond reflects the workload of the practice. Regarding [the Second GP]'s telephone call with Mrs Morrish at 14:00, despite Mum's reticence to drive in the snow, [the Second GP] felt it would be better to see Samuel than give advice over the phone. [The Second GP] had an afternoon clinic and therefore put

- Samuel on the end of his list, hence the appointment at 16:10.
- 3.5.3 During his examination of Samuel, [the Second GP] measured his respiratory rate (although the value is not written down in his medical notes) and checked the value against the list of normal ranges that he has on his wall. He felt Samuel's respiratory rate and pattern of breathing was within normal limits. He auscultated his chest and felt all segments of both lung fields were clear. He examined his throat using a light and tongue depressor. His tympanic membranes (eardrums) were not visualised. When assessing hydration in children, [the Second GP] has a standard approach — he took a history of Samuel's intake which he thought “was plenty”, he looked at his mucous membranes which were wet and took a peripheral capillary filling time, which was less than 2 seconds, ie: suggesting normal peripheral perfusion. He was reassured that Samuel's rash was not spreading nor blanching to suggest meningococcal disease. Towards the end of the consultation he was reassured that Samuel's mental state was normal. His overall clinical impression was that Samuel was suffering from uncomplicated influenza infection. He had seen many other children with similar symptoms that had subsequently got better.
- 3.5.4 Regarding signs of septicaemia, [the Second GP] felt Samuel had normal perfusion, normal mental state and respiratory pattern. His clinical impression was that Samuel was ill but not septicaemic. Samuel's temperature, heart rate and urine output were however not noted.
- 3.5.5 Taking a child's temperature is a routine practice performed by [the Second GP] and other GPs but was not done on this occasion.
- 3.5.6 Measuring heart rate in young children with flu like illness is not part of [the Second GP]'s routine practice.
- 3.5.7 [The Second GP] did not assess Samuel's urine output. I asked him if he had known Samuel had not passed urine for 6 hours would this have changed his management plan. He would not have referred Samuel to hospital for admission as Samuel's other indicators of hydration reassured him, but he would have asked parents to push oral fluids over a 2-3 hour period to see if Samuel passed urine. If Samuel had not passed urine following this fluid challenge, he would have recommended contacting the out of hours doctor service.
- 3.5.8 There is a reported verbal comment by one of the clinicians in Torbay that pneumonia may have been missed” [The Second GP] states that he is experienced at listening at chests and he felt that Samuel's lungs were clear. An abnormal respiratory rate in children is highly sensitive of lower respiratory tract infection — [the Second GP] felt Samuel's respiratory rate was normal.
- 3.5.9 Regarding follow up of patients seen at the surgery, [the Second GP]'s usual practice is to end his consultations stating that if things change, to contact the surgery during office hours and after hours to contact the out of hours doctors service.

3.6 Conclusion and learning points

- 3.6.1 [The Second GP] wishes to apologise that despite his best efforts, he did not pick up Sam was very sick.
- 3.6.2. He has reviewed the NICE clinical guidelines on fever in children under 5 years again.⁸ He has the table summarising the traffic light system for identifying serious illness on his wall. It is his usual practice to ask about urine output in infants to assess hydrating — he will now extend this to pre-school children. He will now routinely measure heart rate on every child he sees.
- 3.6.3 Following Samuel's death [the Second GP] has completed the Royal College of GP's E-Learning Course on upper Respiratory Tract Infections and the Feverish Child. I suggested completing the “Spotting the Sick Child” internet based learning package produced by the Royal College of Paediatrics and Child Health, which he was happy to do.
- 3.6.4 Identifying signs of early septicaemia in preschool children is difficult. Following discussion with [the First, Second and lead GPs], they will now routinely measure heart rate as part of their usual paediatric examination. The traffic light system⁸ does not include heart rate parameters but in the guidelines subsequent text, it states that “healthcare professionals examining children with fever should be aware that a raised heart rate can be a sign of serious illness, particularly septic shock” (section 4.5.2). It cautions that more research is needed “to confirm normal ranges for heart rates at various body temperatures and to determine whether children with heart rates outside these ranges are at higher risk if serious illness” (section 4.5.2.1). Nonetheless tachycardia

in the absence of fever is an important sign to be looked for.

- 3.6.5 Cricketfield Practice will also have a meeting this autumn, to review the most recent advice from the Chief Medical Officer regarding the management of flu like illness in children and adults for the coming winter period.

3.7 Chronology

3.7.1 Susanna Morrish¹

Wednesday 22nd December 6pm-9pm: Calls to NHS Direct/from Devon Doctors.

“We got back from the Cricketfield Surgery shortly after 5.00, Sam wouldn't eat any tea but was still very thirsty and continually sipping his water. He sat to my lap ‘and said his tummy was hurting and was sick into a bowl (about 6pm). Looking at it I thought something wasn't right, there were tiny black streaks in the clear liquid, which looked to me like they could have been blood. I felt worried so phoned the Surgery, when I heard, “The surgery is now closed” I phoned NHS direct. I explained to the lady about my concern for the vomit and she asked several questions which included asking us to check Sam's nappy. It was completely dry. It was at this point we realised that he hadn't weed since 10 am. The NHS direct lady seemed very concerned about this, more so than about the vomit, and said that someone from Devon Doctors would call us back.”

- 3.7.2 At 18.00 pm Mrs Morrish phones the GP Surgery to hear that it is closed and hangs up before listening to the full message which at the end gives contact details for Devon Doctors. Mrs

	Morrish subsequently calls NHS Direct at 18.20 pm and initially speaks to a health advisor. Mrs Morrish states “it is about my son, he has been to the GP yesterday and today with his viral flu that has been going around. However he has just been sick and he hasn’t eaten anything today apart from half a Weetabix. What he vomited up, it’s got lots of dark brown blobs in it.” The health advisor states “I don’t like that; I think it is best if we get you talking to a nurse.”				
3.7.3	At 18.25 pm, Mrs Morrish has an 18 minute telephone consultation with a NHS Direct nurse advisor. ⁹ After identification checks and ensuring that Sam is alright while they talk, being presented with a child vomiting up brown lumps, the nurse advisor follows the toddler aged 1-4 vomiting algorithm. This algorithm consists of 10 sections designed to screen for the different causes of vomiting. Questions 1 and 9 concern sepsis, questions 2 and 3 meningococcal disease, questions 4 and 5 screen for gastrointestinal bleeding, obstruction and blood in stools, questions 6 and 7 screen for vomiting secondary to head injury and hernias respectively, question 8 provides screening question to identify diabetes (this includes an assessment of fluid intake and urine output) and question 10 screens for signs of an acute abdomen.	3.7.5	The nurse advisor questions the nature of the brown lumps in vomit. Despite Mrs Morrish stating “there were blobs in it which were very dark brown which you could describe as coffee colour” and correctly identifying that Samuel had not had anything to eat since 7 am, the nurse advisor feels “I am not convinced it is bleeding” and answers “No” to the vomiting blood or coffee ground-like material question in the algorithm (RCA 2.7.6.5). My impression is that she feels this is not a gastrointestinal bleed, because there are “dark lumps floating in clear fluid” without any evidence of bright red blood and is reassured that it has only happened on one occasion. She does however mention that if it were to continue she would be more worried.	3.7.10	A call is sent by NHS direct to the out of hours doctors service by technical link requesting a routine call i.e. telephone consultation within 6 hours.
		3.7.6	The nurse advisor does not record that Samuel has rapid breathing although his parents think that Samuel’s breathing “might be fast and shallow.”	3.8	Comments
		3.7.7	The nurse advisor quickly identifies that Samuel has not passed any urine since the morning and also that [the Second GP] was not aware of this fact during his consultation.	3.8.1	The NHS Direct nurse advisor was correctly concerned to organise further review for Samuel. The subsequent route cause analysis confirmed that the nurse advisor should have passed this referral through to GP out of hours service as “urgent”, requiring consultation within 2 hours, rather than “routine”, requiring consultation within 6 hours (RCA 2.7.6.4). The RCA confirms the nurse advisor chose to answer “No” to the presence of blood or coffee ground fluid. This does not appear to have been a mistake but a considered judgement to answer “No” and assess further around other symptoms. The review also identified that answers recorded were not consistent with answers provided for e.g. a “No” answer was recorded against the presence of rapid breathing, when Mr and Mrs Morrish had clearly stated “Yes” (RCA 2.7.6.5). The RCA identified individual learning for the nurse advisor involved. I believe this has been addressed and the nurse advisor will have a period of increased support and monitoring for 3 months (RCA 2.7.6.6). I understand the vomiting algorithm has also been subsequently changed. If a child is identified as vomiting black/brown “coffee granules” this is considered an emergency i.e. indicating that an ambulance needs to be called
3.7.4	The nurse advisor does not fully ask all the early questions relating to consciousness and neurology. The answers were ticked as No even though Samuel was ‘increasingly sleepy.’ There has been a recognition that the Nurse Advisor should have probed this question further and clarified the level of alertness/responsiveness more fully. ¹⁷	3/.8	During the telephone consultation, the nurse advisor also identifies that Samuel is febrile, has a blanching rash, ascertains he has a dry mouth and red tongue, abdominal pain and warm peripheries.		
		3.7.9	She finishes her consultation with an overall conclusion “I am not concerned with the fact that he is vomiting dark lumps, but I am concerned with the way he is in general so I know he was seen by the doctor not that long ago but still with the way he is, what I would say is I would like you to have a word with the doctor again, it will be the out of hours		
			doctor now anyway”. The consultation ends with Mrs Morrish stating “okay, so the emergency doctor will phone me”. Nurse advisor “Yes, will call you as soon as they can?”		
			immediately in such cases involving children in the future. ¹⁰	3.8.2	The vomiting algorithm is a poor screening tool for signs of early septicaemia but the telephone consultation did reveal increased respiratory rate, warm peripheries and reduced urine output suggestive of septic shock — this suggests further progression of the illness.
				3.9	Chronology
				3.9.1	Susannah Morrish ¹
					As I waited for the call back I took the phone everywhere with me, upstairs to where I was giving Sam’s brother a bath, and then into my bedroom — where I put it down — while I went to get Sam’s brother out of the bath. It was at this moment the phone rang....but I couldn’t remember where I put it, when I did find it I picked it up and it went dead. I did 1471 and it was a withheld number. I didn’t have anyway of knowing who had called — I didn’t have a contact number for the Doctor who was going to ring me back. However we thought that as they know it’s serious, IF it was them they will try again in a minute and if it wasn’t them we were waiting and needed to keep the landline clear.
					I finished the bedtime routine with Sam’s brother, Scott phoned his parents (on our mobile) it was now nearly 8:30 and I still hadn’t heard anything. I felt really anxious.
					I phoned NHS Direct again at some-time after 8:30 to chase for the call back, I have a recollection of being told that the case had been passed on to the Doctor and that they gave me a number to ring.

At 20:50 I ran Devon Doctors and spoke to a lady who said she would chase the doctor at Newton Abbot to ring us, and that we should hear back in the next 10-15 minutes.

After this it's a blur....Scott went upstairs to check Sam....I remembering him calling to me, Sam has just been sick again and this time it's just all black, and seeing Sam covered in a thick black sticky liquid. I remember thinking doesn't this mean internal bleeding? This is really bad. I knew he needed to go somewhere and fast but I didn't know what was the right thing to do, so I phoned Devon Doctors number again- thinking they will tell me what to do — and this time got put through to a different person at the call centre. That call was at 21:08.

I explained that I had been waiting for a call but my three year old son had just vomited black liquid and asked shouldn't I be taking him somewhere fairly quickly. When it is suggested that I want to go to Newton Abbot I say "If they've got suitable treatment" and the person on the phone assured me that he will work out the best place to get suitable treatment.

When he phones back he told us to go to Newton Abbot saying "they have the same facilities as Torquay and if we went to Torquay they may send us back to NA anyway." And that he would adjust the case details and let NA know we were coming. When we put the phone down it was about 21:20."

3.9.2 Wednesday 22 December 2010

18.44 - 18.51 hrs

Call dispatched to Newton Abbot

Treatment Centre and electronically acknowledged.

3.9.3 19.12 hrs

[Duty GP on call] phones the family home — no answer.

3.9.4 20.52 hrs

Mrs Morrish rings Devon Doctors from her mobile to query if she has missed a call from the doctor at 19:12pm

3.9.5 21.18 hrs

Mrs Morrish phones Devon Doctors out of hours service. The call is answered by a call handler. Mrs Morrish states that the family have been awaiting a call from a GP and Samuel has just vomited black liquid. They discuss the options of either attending the Newton Abbot Treatment Centre or A&E Department at Torbay Hospital. To decide, the call handler phones through to Newton Abbot Treatment Centre as he is unable to speak to either GP on call as they are both busy. He discusses the case with a driver and although in their discussion they acknowledge that it is the family's decision where to take Samuel, between them they would recommend Newton Abbot Treatment Centre due to its proximity. The call handler phones Mrs Morrish back: "I spoke to Newton Abbot, the treatment centre. They said whilst the symptoms do need to be reviewed today, there is no guarantee that the child is going to be admitted, so if you were to go to our treatment centre, our treatment centre has the same facilities in Newton Abbot and in Torbay. If you were to go to the A&E then there is again a chance that you are going to be sent to our treatment

centre and then you will be in the same loop again."

Mrs Morrish questions the decision to go to Newton Abbot Treatment Centre but follows the advice given.

3.9.6 21.19 hrs

[GP duty doctor] phones the Morrishes' family home but gets an engaged tone.

3.9.7 Susanna Morrish¹

"While we were waiting to be told where to go we had already got Sam ready to leave and had arranged to take Sam's brother to a neighbour — we left as quickly as we could and arrived at Newton Abbot just after 9.30. The records have being booked at 9.38.

Scott carried Sam in his arms, I'd never seen him look so pale before. We all went to the reception desk and explained this is Sam Morrish, you should be expecting us, and the receptionist says, yes, we've got you on the system — please take a seat, there are three people in front of you. Hesitantly we sit down I don't understand....I've just told Devon Doctors that he's vomiting black liquid... they already know he hasn't weed for 12 hours...I've discussed on the phone 'shouldn't I be taking him to someone really fast' and the person I spoke to agreed....so why are we being told to wait? Is it not really that serious, are the other three children waiting here also vomiting up black liquid? I'm not a medical person — I am supposed to trust the judgement of the medical staff I have just spoken to.

The anxiety is overwhelming. Sam is hacking away with his cough as we sit and wait, I can't see any medical staff, I

have a cloth ready in my hand in case he starts to vomit again. My mum rings my mobile. Scott pops outside to ring her back. We still haven't been seen, in fact no-one has left the queue at all — it is now 21.50. Now alone in the waiting room I am almost in tears, suddenly a nurse walks by — I think it was 9.55, I call out 'Please can you help me'. She takes one look at Sam and rushes us into a side room. Please be clear about this — the only reason we are seen at the moment is that I ask for help.

Suddenly the Doctor is there, and paramedics and we are in an ambulance being rushed to Torbay."

3.9.8 21.38 hrs

Mrs Morrish and Samuel arrive at Newton Abbot Treatment Centre. They are asked to wait in the reception area and are informed that they are in a queue with 3 patients to be seen before Samuel.

3.9.9 21.58 hrs

[A Nurse Consultant] comes out of the treatment room and sees Samuel in his mother's arms looking extremely unwell. She asks reception for the child's name and advises that she is going to take Samuel through to the resuscitation room. Mr Morrish joins Samuel and his wife at this point. [The Nurse]'s initial assessment reveals a heart rate of 177, capillary filling time 3 seconds, systolic BP 115 mmHg, temperature 37.9, respiratory rate 32, saturations 94% in air, BM 4.6. She notes that although Samuel is awake, his activity is decreased, he is not smiling and he looks pale. She also notes that he is drinking excessively, has a blanching rash and there is a history of blood stained vomiting.

3.9.10 22.01 hrs

Samuel is reviewed by [a GP]. His initial assessment is that Samuel is very unwell. He notes coffee ground vomit stains on his clothes. Samuel is conscious but not speaking and is sitting up. He looks pale. He notes his cardiovascular parameters and that Samuel is also concentrating on breathing with a tracheal tug and use of accessory muscles. His clinical impression is one of respiratory distress and hypovolaemic shock. He administers high flow oxygen but attempts no further resuscitation. He immediately phones the Torbay paediatric team and informs them that Samuel is being blue lighted to their resuscitation department in A & E. He then phones 999. This is all completed by 22:09.

3.9.11 22.18 hrs

The ambulance leaves Newton Abbot Treatment Centre after handover from [the GP]. Samuel is cardiovascularly stable during transfer. Develops pyrexia of 38.7°C and a bilateral wheeze is noted by the ambulance staff.

3.9.12 22.28 hrs

Arrival at Torbay Hospital A & E department resuscitation area. Samuel is reviewed by a Paediatric Registrar.

3.9.13 [The Paediatric Registrar]¹²

“Samuel looked very unwell; he was breathless and needed 10-15 L of oxygen in order to maintain oxygen saturation. His capillary refill time was six seconds and he looked tired though he was fully conscious, he also had a temperature 38.5°C. As he was showing signs of being critically ill I discussed with the nurse and immediately

commenced resuscitation. A blue intravenous cannula was inserted and blood was taken for testing including blood grouping and blood culture. His blood sugar was normal. He was given a 20 ML/KG 0.9% saline bolus. When the fluid was being given he showed signs of improving and his capillary refill time improved.” (Blood investigations: peripheral gas - pH 7.36, pCO₂ 4.6, BE -5.4, HCO₃ 20, lactate 3.5)

3.9.14 [The Paediatric Registrar]¹²

“I was concerned that Samuel may be having severe pneumonia or infection related intra-abdominal bleeding. I discussed with Samuel’s parents, they were aware that Samuel was quite unwell.

While resuscitation was being done I telephoned the consultant paediatrician on-call and informed him about Samuel’s condition and what we have done so far to treat him. I also explained that I am concerned that Samuel was very unwell. The consultant paediatrician advised me to continue with the plan of management including having a second intravenous cannula, chest and abdominal x-ray and obtaining surgical opinion and ITU specialist opinion, the consultant paediatrician will arrive and assess the patient.

The instructions were carried out and [the consultant paediatrician] arrived within 10 min. Intravenous Ceftriaxone and intravenous Ranitidine was prescribed. The chest showed extensive consolidation of the right lung field with loss of volume, consistent with a pneumonia. By this time Samuel’s capillary refill time had improved to 2-3 seconds indicating good response to fluid resuscitation.

The surgical team arrived and assessed Samuel. Their opinion was that Samuel was unlikely to have an acute abdomen. The ITU team also assessed Samuel. [The consultant paediatrician] discussed with paediatric nurse and arranged for Samuel to be admitted and managed in paediatric HDU.”

3.9.15 Susannah Morrish¹

“I understand that the treatment and tests at Torbay hospital have been well documented however there are a few points we would like to make. Shortly after arrival, we explained to one of the registrars that Sam had been seen by the duty doctor at 4.30pm and sent home, and that the doctor had examined Sam and said his lungs were clear. 5 hours later an x-ray showed, one lung completely full/white. The assumption of the registrar was that the GP had made a mistake, “what was the GP thinking of sending us home?” Rather than thinking if the lungs were clear at 4.30pm, and are now full, how quickly is Sam’s condition deteriorating? Focus was put on treating the pneumonia, rather than vomiting blood, as Sam didn’t appear to have any abdominal tenderness. [The consultant paediatrician] has also noted that there was a 1 and a 1/2 hour delay between Sam’s arrival and the administration of antibiotics. They weren’t given until Sam’s arrived in HDU when they should have been given in A+E. Septicaemia is described as a “race against time”, every minute counts. By 5am on the 23rd December Samuel had died from Septic Shock.”

3.9.16 [The Paediatric Registrar]¹²

Thursday 23 December 2010

01:45 hrs

“After seeing the patients in A&E, I arrived in paediatric HDU to review Samuel. He was breathless and needed 80% oxygen to maintain saturation. Though his capillary refill time was three seconds, he had weak radial pulse and warm peripheries. His blood gas showed mild acidosis and a base excess. He had not passed urine since change of nappy three hours ago. This was despite having a total of 30 ML/KG of fluid boluses in addition to maintenance fluids.”

(Entry in medical notes: Heart rate 110-140, CRT 3 secs, weak radial pulse, femoral well palpable, warm peripheries. Resp rate 72-80, Sats 90% in 80% O₂, not passed urine 3 hrs since nappy change).

3.9.17 [The Paediatric Registrar]¹²

“I was beginning to think that Samuel was starting to develop signs of early septic shock. Samuel’s CRP was 442, indicating infection. I contacted [the consultant paediatrician] over the telephone and explained Samuel’s condition and my concerns and I also explained I was considering Samuel may need admission to ITU and inotropes to support his possibly failing circulation. [The consultant paediatrician] advised me to give Samuel another two fluid boluses of 10 ML/KG each and reassess Samuel and to inform him if I am still concerned.”

(Blood investigations available at time: Haemoglobin 10.1, WCC 3.0, Platelets 293, Lymphocytes 0.3, Neutrophils 2.7, INR 1.2, APTT 33.7, Fibrinogen 6.8, Sodium 134, Potassium 4.0, normal renal

function, CRP 442, peripheral gas - pH 7.29, pCO₂ 5.26, BE -7.1, HCO₃ 18.5, lactate 3.1).

3.9.18 [The Paediatric Registrar]¹²

“Approximately 02:30 hours 23/12/2010. Consultant Anaesthetist arrived and assessed Samuel. I discussed and explained my observations and impression. Senior nurse in charge and I had a discussion and we were both concerned that Samuel continued to remain very unwell.”

3.9.19 The Paediatric Registrar¹²

03.30 hrs

“Samuel still needed 80% oxygen and was looking even more unwell. He had a small bleed in his nose and mouth and was becoming restless and agitated. His capillary refill time had worsened again (five seconds). He developed a blanching rash all over his body. Samuel looked extremely unwell.

My impression was Samuel will need immediate ITU admission though I realised Samuel's condition was quite advanced at this stage. I contacted [the consultant paediatrician] over the telephone and explained that I am extremely concerned about Samuel's condition and asked that the consultant paediatrician attend and assess Samuel as soon as possible. I also explained that I would like to discuss Samuel with Bristol PICU team, and obtained his approval.

I was then talking to Bristol PICU registrar regarding Samuel. The decision was to stabilise Samuel and contact PICU later. While I was talking to the registrar, [another docto]r arrived

and informed me that Samuel had a respiratory arrest and the anaesthetist was resuscitation and was going to intubate.

I arrived at Samuel's bedside and assisted in resuscitation. The ITU consultant arrived and led the resuscitation. Later Samuel had a cardiac arrest and was bleeding through his mouth and nose. [The consultant paediatrician] arrived, he also explained to the parents regarding the events. Samuel was intubated, had several doses of Adrenaline, Bicarbonate and blood.”

(Blood investigations: peripheral gas at 03.39am - pH 6.995, pCO₂ 7.69, BE — 18.1, HCO₃ 10.5, lactate 10; peripheral gas at 04.17am - pH 6.65, pCO₂ 12.4, BE — 28.8, HCO₃ 5.0, lactate 17).

3.9.20 Resuscitation attempts were unsuccessful. The decision to stop Samuel's resuscitation was taken by [the consultant paediatrician] and [an ITU Consultant] and Samuel was sadly certified dead at 5:05am.

3.9.21 Post Mortem Report¹³

“The body is of a male child. There are no injuries and no evidence of significant malformations. DNA extracted from uncultured tissue showed no evidence of aneuploidy, triploidy or chromosome imbalance arising from deletion or duplication of any subtelomeris region. Toxicology is negative.

The main finding at post mortem is of heavy, oedematous and haemorrhagic lungs. The right lung weighs 291g and the left lung weighs 250g. The right lower lobe feels consolidated. On histology, the lungs are congested. They show

extensive pulmonary oedema and there is focal necrosis. The blocks of tissue from the right lower lobe show extensive haemorrhage and necrosis of the lung with evidence of acute pneumonia. In the location bronchioles and bronchi contain large numbers of neutrophil polymorphs. In places the lungs are completely necrotic and contain huge number of cocci.

The naso-pharyngeal aspirate in influenza B PCR- Positive.

Bacteriology from the lungs show ++ Beta haem. Streptococcus group A and the live shows scanty Beta haem. Streptococcus group A. It is my understanding that Group A Streptococcus has been grown from blood culture (telephoned report).

Lung and liver virology shows HHV 6 PCR positivity.

Tandem Mass Spectrometric Analysis of Acylcarnitine showed no significant abnormality detected.

Urinary organic acid analysis by GC-MS showed moderate lactic acidosis.

Mild ketosis.

Given the extensive haemorrhage in the infected and necrotic lungs it is considered that the haemorrhage is likely to have come from the lungs.

Conclusion:

Male Child

Beta haem. Streptococcus pneumonia

Nasopharyngeal aspirate: Influenza B PCR positive

Liver and Lung: HHV 6 PCR positive.”

3.10 Comments

3.10.1 By the time Samuel reaches Newton Abbot Treatment Centre at 21:58, he has signs of respiratory difficulty and shock (high pulse rate in the absence of fever and poor peripheral perfusion). The GP correctly identifies this, starts high flow oxygen but then elects to transfer Samuel rapidly to Torquay rather than attempt further resuscitation. This course of action can be debated: on the one hand resuscitation should be attempted once shock is identified and patients ideally need to be stable for ambulance transfer. On the other hand it can be technically difficult to cannulate a 3yr old in shock and an experienced paediatric team was available a 10 minute drive away.

3.10.2 In A&E [the Paediatric Registrar] shows good clinical judgement, quickly identifies how ill Samuel is, resuscitates appropriately and informs [the paediatric consultant] on call of Samuel's condition. Samuel responds well to a fluid bolus with an improvement in perfusion.

3.10.3 Reviewing the prescription cart, IV Ceftiaxone (a broad spectrum antibiotic) is prescribed between 22.30-23.00 hrs but is not administered until Samuel is on HDU at 01.30 hrs (23 December).

The delay in administration of antibiotics is commented on in the RCA (2.7.11.2):

“The key point from South Devon Healthcare Trust (SDHCT) investigation relates to the time after Sam's arrival at A&E. Antibiotics had been prescribed in A&E but had not been administered until after his arrival on the ward. [SDHT] noted that part of the problem appears to be the lack of a paediatric

nurse overnight in A&E, combined with reluctance for A&E staff to calculate doses for children and administer them. This appears to be picture nationally as there is a shortage of paediatric trained nurses working in A&E. Nurses in A&E can also request doctors to do the calculations and administer first doses.”

The suggestion that A&E nurses are not sufficiently trained to administer paediatric medication is refuted by [the consultant paediatrician] in an e-mail response to Mr Morrish’s queries dated 22.6.2011. He states that “All trained nursing staff in A&E are sufficiently qualified to administer antibiotics on paediatric patients.”

I discussed the above with [the consultant paediatrician] over the telephone on 26th August 2011. He stated it was regrettable that the antibiotic had been administered late. He wonders whether in an attempt to expedite the admission to HDU, a decision was made for the antibiotic to be administered once Samuel had arrived on HDU.

- 3.10.4 In an e-mail response to Mr Morrish’s queries (22.6.2011), [the consultant paediatrician] explains the decision to move Samuel from A&E to the children’s HDU in Torbay and not e.g. make a referral to Bristol PICU.

“After the initial resuscitation phase in which Sam was given fluid and oxygen the clinical picture was such that the HDU was deemed most appropriate.

This decision was made by experienced clinicians, the paediatric consultant and the consultant from ITU.

The decision was made on stability of Sam’s vital signs including blood pressure, pulse, blood gases, capillary refill, state of consciousness etc.”

- 3.10.5 [The Paediatric Registrar]’s review at 01:45 however shows that Samuel’s condition has worsened and from then on Samuels shows signs of decompensated septic shock i.e. weak pulse and poor peripheral perfusion with an evolving acidosis despite fluid resuscitation, agitation and difficulty maintaining saturations on oxygen . The very high CRP and low white cell count are worrying signs, signifying overwhelming infection.

[The Paediatric Registrar] phones [the consultant paediatrician]. He suggests further fluid boluses and asks to be phoned back if they’re ineffective with a plan then to phone Bristol PICU. [The Paediatric Registrar] phones back at 3:30 asking [the consultant paediatrician] to come in and then contacts Bristol PICU. It is at this point that Samuel arrests — initially respiratory. Intubation fails to improve his blood gases and Samuel subsequently has a cardiac arrest which does not respond to prolonged resuscitation (8 doses of adrenaline).

BACKGROUND INFORMATION ON INVASIVE GROUP A STREPTOCOCCAL INFECTION

Group A Streptococcus (GAS) is a bacterium often found in the throat and on the skin. People may carry Group A Streptococci in the throat and have no symptoms of illness. Most GAS infection are relatively mild characterised by a sore throat, fever and a red rash (called Scarlet Fever). Occasionally these bacteria can cause severe disease and occur when bacteria get into parts of the body where they are usually not found such as the blood, muscle or the lungs.

One of the forms of invasive GAS disease is Streptococcal Toxic Shock Syndrome —this is the condition Samuel suffered from. Toxic Shock Syndrome is a result of toxins produced by the bacteria that cause septic shock, pneumonia and multi-organ failure. Mortality associated with this condition is said to be up to 10% in children.¹⁴

Classically Streptococcal Toxic Shock is most commonly found following chickenpox or during the use of non-steroidal anti-inflammatory drugs. In December 2010 however, clinicians at the Health Protection Agency became increasingly concerned about the increased incidence of severe illness due to influenza infection requiring access to critical care services with 11 deaths being reported since September 2010 (age range 4-51 years; 4 cases under 10 years). This was communicated to all clinicians via the Chief Medical Officer¹⁵. Subsequently rapid communications from the Health Protection Agency published in February showed an increase in invasive Group A Strep and Strep pneumoniae infections above the seasonally expected levels in England for December 2010 to January 2011. Preliminary analysis suggested that the high level of influenza activity seen that winter may have contributed to an increased risk of concurrent

invasive bacterial infections in children and young adults¹⁶.

This all suggests that the increase in influenza we have seen over the last few years is a significant risk factor for invasive Group A Strep infection. Early recognition of this disease is important but often difficult. Management includes haemodynamic stabilisation and appropriate antibiotic therapy to eradicate the bacteria. Supportive therapy, aggressive fluid resuscitation and vasopressor drugs remain the main elements of treatment.

CONCLUSION OF CLINICAL ROOT CAUSE ANALYSIS

Cause of Death

Samuel died from invasive Group A streptococcal pneumonia and septicaemia. His post mortem also revealed Influenza B infection.

Confounding factors

The following factors led to a delay in treatment that may have altered Samuel's outcome:

- a. [The Second GP] attributing Samuel's symptoms and signs to straight forward influenza rather than being complicated by a secondary bacterial infection.
- b. Lack of robust follow up arrangements following consultation with [the Second GP]
- c. Failure by the NHS Direct Nurse Advisor to accurately record the symptoms and signs presented to her
- d. Decision by the Call Handler to recommend Newton Abbot Treatment Centre without consulting with a medical practitioner
- e. Delayed administration of intravenous antibiotics at Torbay Hospital

LEARNING POINTS

- 1. General Practitioners need to be aware that there is a risk of invasive Group A Streptococcal disease during an influenza epidemic / pandemic. For those children who require oral antibiotics I would follow the Department of Health Flu guidelines which recommend Amoxicillin as first line. I would reserve a 10 day course of Penicillin for those children who have signs suggestive of GAS i.e. high fever

with sore throat with/without classic rash. Restricting the use of non-steroidal anti-inflammatory drugs such as ibuprofen is more controversial. Ibuprofen helps a lot of children with simple viral infections and sore throats. In children who are admitted to hospital with obvious toxic shock, its use may be limited, but again the evidence for this is contradictory.

- 2. I think it is important that GPs consider measuring heart rate in pre-school children as part of their routine practice — tachycardia in the absence of fever in an ill child is an important sign not to be missed. Assessment of urine output is also important in the assessment of hydration. The GPs at Cricketfield Surgery have been deeply saddened and troubled by Samuel's death and have taken time to reflect upon their practice. The Spotting the Sick Child internet teaching tool produced by the Royal College of Paediatricians and Child Health is helpful in consolidating one's knowledge and the practice will be meeting before this winter to review any advice from the Chief Medical Officer in the treatment of children and adults with influenza.
- 3. Mr and Mrs Morrish very much wish for the Surgery to review the processes that underpin their telephone triage service — is there a 'fast track' process for sick children? Are all calls dealt with sequentially? The parents would like clarification regarding this.
- 4. The tragic sequelae of events following Samuel's review by [the Second GP] highlights to me the importance of making robust follow-up arrangements. NHS Direct is in essence a triage service who skilled operators often have no prior knowledge of the case and deal with questions as they are presented to them. In Samuel's case the focus on vomiting meant the

nurse advisors clinical impression will have been skewed. Nonetheless, if there is any suggestion of a gastrointestinal bleed this is a medical emergency and should be admitted to hospital. The vomiting algorithm has now been amended with direct referral to hospital as an outcome measure.

- 5. Mr & Mrs Morrish were under the impression that the decision recommending Newton Abbot Treatment Centre over Torbay Hospital was a clinically derived one. This was subsequently found not to be the case. Again decisions were made for practical geographical reasons and with good intention (Newton Abbot Treatment Centre was very close to the Morrish's and was on the way to Torbay Hospital) but was not based on clinical reasoning.
- 6. Resuscitation of children with invasive Group A Streptococcal disease needs to be prompt and aggressive to maximise the chance of survival. It is easy in retrospect to say when this should have happened but by the time Samuel presented to Torbay A&E he was already very unwell. He did initially respond to fluid resuscitation. Earlier administration of antibiotics, therapies directed at neutralising endotoxins eg Clindamycin/intravenous immunoglobulin, earlier intubation and ionotropic support may have helped Samuel to survive. The majority of this care would have had to have occurred on an Intensive Care Unit. Torbay Hospital has a children's High Dependency Unit and one bed on an adult ITU which is used to stabilise children prior to transfer to a larger paediatric intensive care unit — the nearest from Torbay being Bristol. Given that Samuel had signs of decompensated shock in the early hours of the morning, elective intubation at that time and

transfer in an ambulance to a PICU would also have been associated with a high risk of mortality.

Unlike the non-blanching rash seen in meningococcal disease (that can be looked for using the 'glass test'), there is no obvious symptom or sign in the early stages of invasive Group A streptococcal infection that is pathognomonic. To detect this disease we are therefore reliant on good surveillance by primary physicians, robust follow-up arrangements for ill children and prompt and aggressive resuscitation in severe septicaemia.

Rest in Peace, Samuel.

[Name of]

Consultant Paediatrician

30/08/2011

4. Family care review

4.1 Parental experience

A lack of bereavement support for both parents and Sam's older brother has been recounted by Mr and Mrs Morrish (narrative account from Mr Morrish sent to [name] 23/06/2011). Mr Morrish recounted the kindness and compassion shown by the Chaplain, who drove him and his wife home in the early hours of 23/12/2010.

Despite initial contact from the GP Surgery (via Sam's grandmother) and [the consultant paediatrician], the Morrish family report the absence of personal, face to face bereavement support. The family report a catalogue of contacts instigated by them to the GP and Consultant Paediatrician over a five month period, culminating in an approach to the Chair of the RCA Process.

The result of the latter contact was the beginning of bereavement support for Sam's brother being identified through [name], Health Visitor, Devon PCT. Mr Morrish has acknowledged the apology received from [name] for the mistakes that were made regarding communication between the Public Health Nursing Team and Sam's brother's school and is grateful for the help provided specifically for Sam's brother.

With regard to bereavement support and counselling for Mrs Morrish, after repeated requests to the GP surgery, the family report receiving a national list of registered counsellors rather than a local contact which would have been much more helpful. Mrs Morrish described her frustration at not being able to identify whom she should contact, with no

knowledge of which individual from the national list might be skilled in the field of bereavement counselling.

Mr and Mrs Morrish report requesting bereavement support, especially for Sam's brother from the GP practice -

"They told us that although they, as GPs could not help, they could in their own words 'signpost us: that's what we do' [the First GP]. For us this was a relief. So we waited."

A three month period elapsed and although Mr and Mrs Morrish report they were sent an email from the GP practice on 8 March containing a list of websites, what they wanted and needed was a person to talk to, who was experienced in bereavement counselling and able to help with an unexpected traumatic child death (Mr Morrish narrative account — accessing bereavement support/counselling through the NHS).

Mr and Mrs Morrish report what they perceive to be confusion relating to whose responsibility it was to organise initial and ongoing bereavement support for themselves and, importantly, Sam's brother -

"For months, we got the feeling that the GPs thought the hospital should have helped us, because that is where Sam died. For months, we got the feeling that the hospital thought that the GPs should be the people to help us, because they were our GPs. For months no one mentioned anything to the Public Health Nursing Team and for months — we have not been given the help we were asking for" (Mr Morrish narrative account).

They described their experience as frustrating and confusing leaving them expressing -

"It felt like no-one cared...we felt helpless, angry and isolated. Support should have come from one of the agencies, an advocate, someone consistent" (Meeting with Reviewer 22/07/2011).

Mr and Mrs Morrish reported unanswered questions in relation to the Child Death Overview Process and whether it was followed in Sam's case.

4.2 National Guidance

The HM Government document *Working Together to Safeguard Children* (HM Gov 2010) outlines the processes to be followed in the event of an unexpected child death. This guidance intends that the relevant professionals and organisations work together in a co-ordinated way, in order to minimise duplication and ensure that the lessons learnt contribute to safeguarding and promoting the welfare of children in the future. Care of the family forms a central component of the guidance in relation to unexpected death and states -

"It is intended that those professionals involved (before and/or after the death) with a child who dies unexpectedly should come together to respond to the child's death....The work of the team convened in response to each child's death should be co-ordinated, usually, by a local designated paediatrician responsible for unexpected deaths in childhood. The joint responsibilities of these professionals include -

- responding quickly to the unexpected death of a child;

- making immediate enquiries into and evaluating the reasons for and circumstances of the death, in agreement with the coroner;
 - undertaking the types of enquiries/ investigations that relate to the current responsibilities of their respective organisations when a child dies unexpectedly. This includes liaising with those who have ongoing responsibilities for other family members;
 - collecting information in a standard, nationally agreed manner (see paragraph 7.2 and footnote 118);
 - providing support to the bereaved family, and where appropriate referring on to specialist bereavement services; and
 - following the death through and maintaining contact at regular intervals with family members and other professionals who have ongoing responsibilities for other family members, to ensure they are informed and kept up-to-date with information about the child's death."
- HM Gov 2010 pp220 — 221)

The guidance proposes that a case discussion meeting should be held once the final post mortem result is available. The main purpose of the case discussion is to share information to identify the cause of death and/or those factors that may have contributed to the death, and then to plan future care for the family

(HM Gov 2010 p143)

4.3 Local guidance and process

4.3.1 Child death overview process

At the time of Sam's death, across the Southwest Peninsula, local translation of the national guidance was in operation; Peninsula Child Death Overview — Protocols and Working Procedures [January 2009]. The afore mentioned document details processes for notification of all death of children under 18 years of age to the Peninsula Child Death Overview Panel [CDOP] Office. In an Acute Trust, the document states, the Child Death Overview Coordinator should be informed of the death as soon as practicable.

From discussion with the Rapid Response Practitioner [telephone conversation 03/08/11] and the Peninsula Child Death Review (CDR) Service Manager [telephone conversation 18/08/11] the reviewer understands that standard practice following a rapid response referral is -

- Call received
- Contact made between Rapid Response Practitioner [RRP] and referring paediatrician. A decision is made determining if a Rapid Response is appropriate — this is determined using set criteria including if the death is unexplained as well as unexpected.
- If Rapid Response referral is accepted:
- RRP attends hospital, reviews medical notes and speaks to clinicians involved
- RRP contact made with family and home visit arranged; usually same day

- Following home visit, single point of contact established between RRP and family
- RRP contact with other agencies, such as GP, Health Visitor to access support for the family
- Consideration made of need for Strategy Meeting — this is a meeting of professionals involved in the child's care. All agencies involved in the child's care are identified. A review of the events surrounding the death are considered, together with coordination of reports to be made available for the Local Case Review
- Local Case Review meeting organised for a date following the Post Mortem report availability
- Family informed of date for Local Case Review Meeting. RRP discusses with the family if there are any key issues, from their perspective they feel should be addressed at the Local Case Review meeting
- Local Case Review meeting held. Recommendations made and report presented to the Child Death Overview Panel
- Family made aware of the outcome of the Local Case Review.

If a Rapid Response is determined inappropriate, the Paediatrician is assumed to be the lead professional in terms of 'duty of care' for the family.

In the event a Rapid Response is not initiated, the Child Death Overview Panel will still review the child death, but this may not occur for many months, as they will wait for the post mortem and inquest findings to be available.

If when the child death is considered by the Child Death Overview Panel, learning or concern is expressed relating to care provision, the CDR Service Manager informed the reviewer that an approach would be made to the commissioner of those services. Any information arising from the Child Death Overview Panel would be available for use in the commissioner led investigation.

The CDR Service Manager informed the reviewer that the CDOP practitioners are not themselves bereavement counsellors and she perceived there to be a gap in terms of bereaved parents accessing bereavement support following the death of a child.

4.3.2 South Devon Healthcare NHS Foundation Trust

South Devon Healthcare NHS Foundation Trust [SDHFT] - the reviewer requested from SDHFT any bereavement policies or guidelines relevant to child death. The Dying Child — Bereavement Guidelines were supplied. The guideline proposes the identification of a co-ordinator; a senior nurse, middle grade doctor or consultant to "ensure that the necessary people are informed, and necessary tasks undertaken". The guideline states that the checklist within the guideline should be completed by the co-ordinator and retained in the medical notes. The checklist includes consideration of other professionals that need to be informed, such as the Health Visitor.

4.4 The Morrish family care review

4.4.1 Child death overview process

Following Sam's death on 23/12/2010, a notification form was completed by South Devon Healthcare NHS Foundation Trust (SDHFT) and it is reported that this was emailed to the Southwest Child Death Overview Panel office on the same day. Whilst a Rapid Response Referral was not made, the reviewer is informed that a conversation between the CDR Service Manager and the Consultant Paediatrician took place on 23/12/2010. A decision was made at this point that a Rapid Response was not appropriate as whilst Sam's death was unexpected, it was not unexplained, such that the suspected cause of death was flu complicated by septicaemia.

Therefore, in line with CDOP process detailed above, the Paediatrician assumed the role of lead professional in terms of 'duty of care' to the family.

From analysis of the organisation reports, there is evidence that the Paediatrician informed the GP of Sam's death on 23/12/2010 via telephone (see timeline, Annex A). It is not clear however, if bereavement support was discussed at this point. A letter was also sent to the GP dated 30/12/2010 from the Paediatrician informing the GP of the post mortem findings. The letter also highlighted that the Paediatrician would be in touch with the family in two weeks hence, to arrange for the family to meet with the Paediatrician to address any unanswered questions the parents had. It is evident that the Paediatrician maintained contact with the family, either via telephone or meetings on 30/12/2010, 17/01/2011, 30/03/2011 (meeting requested by Mr

Morrish) and 06/05/2011 where the Paediatrician met Mr and Mrs Morrish accompanied by MP, from the Child Death Overview Panel office.

4.4.2 Bereavement support

In line with the afore mentioned guideline, the South Devon Healthcare NHS Foundation Trust [SDHFT] medical notes record that the Bereavement Office phone number was given to Mr and Mrs Morrish on 24/12/2010. Mr and Mrs Morrish had in their possession a leaflet they had been given from the Bereavement Office when the reviewer met them.

Within the case bundle of papers supplied to the reviewer, a statement from a Staff Nurse caring for Sam reports the presence of a Minister at the parent's request shortly after Sam died

There is no evidence of the checklist in the SDHFT medical notes supplied for the purpose of the independent review.

The RCA Investigation report from SDHFT identified an action from its analysis of the events surrounding Sam's death relating to improving the provision of bereavement information for parents following the death of a child. This point is further reiterated in the SDHFT summary of learning and actions taken following Sam's death (Section 6).

A Clinical Psychologist referral was made by the Paediatrician following a meeting requested by Mr and Mrs Morrish at the end of March 2011. The referral letter, dated 01/04/2011 was copied to the GP.

With regard to bereavement support for Sam's brother, Mr Morrish reports

receiving an apology from the Health Visitor for confusion in communication between the Public Health Nursing Team and Sam's brother's school; the result of which led to no contact established between the Public Health Nursing Team and the family.

The GP surgery contacted the family following Sam's death but conversed with Sam's grandmother in the first instance. It appears that the GP surgery did not discuss bereavement support at this point. There is evidence that one of the GPs visited Mr and Mrs Morrish at home on 17/01/2011 but again it appears that bereavement support was not actioned as a result of this visit.

Following a meeting between Sam's parents and the GP surgery later in January, Mr Morrish reported that the GP surgery had agreed to 'signpost' them to bereavement support agencies. The GP surgery acknowledge the significant delay in providing guidance with regard to bereavement support and outline that more information should have been freely available between the hospital and the surgery with respect of who was responsible for initiating bereavement support (Organisational Learning, Section 6).

4.5 Family care review — summary findings

- Notification of Sam's death was made to the Child Death Overview Panel Office on 23/12/10.
- Following a decision that a Rapid Response Referral was not indicated, the Paediatrician assumed the role of lead professional in fulfilling a 'duty of care' to the family following Sam's death.

- South Devon Healthcare NHS Foundation Trust has a bereavement following the death of a child guideline. There is evidence of partial implementation of the guideline; there is no evidence of the checklist in the supplied medical notes.
- Following Sam's death, details of the SDHFT Bereavement Office were given. SDHFT identified an action from its analysis of the events surrounding Sam's death relating to improving the provision of bereavement information for parents following the death of a child.
- The Paediatrician informed the GP of Sam's death but it is not clear whether bereavement support was discussed or who was to provide it. As a consequence, Mr and Mrs Morrish were left in a position where they had to pursue counselling support themselves.
- Repeated requests for bereavement counselling/support were made by Mr and Mrs Morrish to the GP Practice. The GP Practice acknowledge the significant delay in providing guidance with regard to bereavement support and outline that more information should have been freely available between the hospital and the surgery with respect of who was responsible for initiating bereavement support.
- There was confusion related to the Child Death Process, the Rapid Response Process and the provision of bereavement support.
- Following a meeting between the Paediatrician and Mr and Mrs Morrish, a clinical psychology referral was made and help has now

been provided in this regard for Mr Morrish. Mrs Morrish is receiving counselling support now via the GP surgery.

- There is evidence that Sam's brother's school was contacted but no contact was established between the Public Health Nursing Team and the family with regard to bereavement support for Sam's brother. The Health Visitor has apologised to Sam and his brother's parents for this error.
- Sam's brother is now receiving bereavement support.

If root causes are to be proposed with regard to the lack in provision of bereavement support for both Mr and Mrs Morrish and Sam's brother, they are those of assumed responsibility and poor communication.

It should be noted that apologies have been given and acknowledgement made, resulting in actions planned to improve the care of families — for both parents and siblings in relation to bereavement care in the summaries from the agencies found in the Organisational Learning — Section 6 of this report.

Recommendations that aim to prevent a similar situation arising in the future can be found in the Recommendations — Section 7 of this report.

5. Investigation review

5.1 Parental experience

Reported feelings from Mr and Mrs Morrish in respect of the investigation include feeling abandoned, ignored and pushed aside;

“The NHS as a whole has made us feel like an irrelevance — a side-show to the investigation into the ‘unexpected’ death of our own child”

Mr Morrish particularly recounted many occasions where he had been compelled to ‘drive’ the process; volunteering information, seeking answers to questions about Sam’s care, chasing organisations for information and feeling that he and his wife were in an information void due to the lack of proactive communication from the NHS.

Sam’s parents informed the reviewer that -

“the sheer lack of urgency that has characterised the whole RCA process, until very recently, was extraordinary, quite apart from the fact that it managed to forget about us (Sam’s parents) — until we started to call all of you!”

Mr and Mrs Morrish requested the voice recording of the NHS Direct and Devon Doctors’ calls. They were sent the recordings and listened to them on their own; an experience they believe no other parent should have to endure.

The final report presented to Mr and Mrs Morrish caused further frustration and anger with a process, which from their perspective, failed to achieve its original objective of determining why

Sam had died unexpectedly. Mr and Mrs Morrish reported -

“The RCA process itself has been so inept, such a waste of time, and so pointless up until now, that in the end it has dragged us back again and again to the most traumatic events that any parent could suffer’

5.2 National Guidance

5.2.1 Investigation

An investigation is described as -

“a systematic, minute, and thorough attempt to learn the facts about something complex or hidden; it is often formal and official” (www.dictionary.reference.com).

Within the NHS, the National Patient Safety Agency (NPSA) provides a framework within which incident investigation takes place. A common methodology employed within the NHS is that of Root Cause Analysis Investigation. Root cause analysis (RCA) is described as -

“a problem solving methodology for discovering the real cause(s) of the problems, or difficulties, identified via a range of activities including incident management” (Dineen 2002 p.5).

A key outcome of any investigation, as with those using RCA as a methodology, is that lessons are learnt and corrective action taken in a bid to minimise the risk of reoccurrence.

However it is noted that RCA is not a single, sharply defined methodology; rather that there are many RCA tools and techniques, such as 5 Whys, Effects Analysis, Cause Mapping, Fault Tree Analysis, Barrier Analysis (IMS

International 2011) which together can be used under the auspices of Root Cause Analysis and form part of an investigation (NPSA 2011).

The National Patient Safety Agency (NPSA) provides guidance to ensure that patient safety RCA investigations are conducted at a level appropriate and proportionate to the incident, claim, complaint or concern under review.

Three levels are suggested:

Level 1 — Concise investigation

Level 2 — Comprehensive investigation

Level 3 — Independent investigation

“Level 2 — Comprehensive investigation:

Commonly conducted for actual or potential harm or death outcomes from incidents, claims, complaints or concerns.

Conducted to a high level of detail, including all elements of a thorough and credible investigation.

Includes use of appropriate analytical tools (eg. Tabular timeline, contributory factors framework, change analysis, barrier analysis). Normally conducted by a multidisciplinary team, or involves experts/expert opinion/independent advice of specialist investigator(s). Conducted by staff not involved in the incident, locality or directorate in which it occurred.

Overseen by a director level chair and/or facilitator.

Led by person(s) experienced and/or trained in RCA, human error and effective solutions development.

Includes patient/relative/carer involvement and should include an offer to patient/relative/carer of links to independent representation or advocacy services.

May require management of the media via the organisation’s communications department.

Includes robust recommendations for shared learning, locally and/or nationally as appropriate.

Includes a full report with an executive summary and appendices.” (NPSA 2011)

5.2.2 Being open

A critical component of incident investigation is the communication with patients, their families and carers following a patient safety incident and a NPSA Alert were published in November 2009, entitled Being Open [NPSA 2009]. Being Open provides a set of principles that healthcare staff should use when communicating with patients and their families/carers’ and supports a culture of openness, honesty and transparency, and includes apologising and explaining what happened;

“Being open when things go wrong is key to partnership between patients and those who provide their care. Openness about what happened and discussing patient safety incidents promptly, fully and compassionately can

<p>help patients cope better with the after effects” (NPSA 2009 p.6)</p>			<p>identified as agencies involved in Sam’s care.</p>
<p>The NPSA advocates that information is given to patients and their families based solely on the facts known at the time, but making clear that new information may emerge as an investigation is undertaken. In addition it is stated that a single point of contact should be established for any questions or requests patients and their families may have. Delays are acknowledged as having a likely consequence of increased anxiety, frustration or anger particularly in relation to receiving an apology, where it is appropriate (NPSA 2009)</p>	<p>Open principles. The protocol makes reference to the Trust Hazard Incident Policy and Procedure regarding the management and incident investigation process.</p> <p>5.3.2 GP Surgery</p> <p>The GP Surgery, in their summary learning points (see Section 6) report an “unwritten system which the surgery has always operated whereby the GP of the patient (or their next of kin) is responsible for getting in touch as soon as is reasonable, either by phone or visit”</p> <p>With regard to the reporting of Serious Incidents by GPs, Appendix D of NHS Devon’s Incident Reporting Policy — NHS Devon Commissioning Arm, November 2010 details the process to be followed.</p>	<p>5.3.5 NHS Devon</p> <p>NHS Devon operates under a comprehensive framework covered by an Incident Reporting Policy - NHS Devon Commissioning Arm, November 2010. Appendix H of the policy details the process for investigation. Appendix R of this policy is a standard operating procedure for Being Open. In addition there is reference made within the standard operating procedure to the NHS Devon Being Open Policy.</p>	<p>In contrast with NHS Devon Incident Reporting Policy, it is not clear if the Patient Safety and Quality Manager was the lead investigating officer.</p> <p>There is no reference made by any agency to seeking involvement of the family as part of the individual organisations investigations, although it should be acknowledged that SDHFT, through the Paediatrician, had established a relationship and was in contact with Sam’s parents. It is also not clear if there was discussion where one individual was to be responsible for seeking the involvement of Mr and Mrs Morrish on behalf of all agencies in terms of the investigation.</p>
<p>A section of the Being Open principles focuses on patient issues or in the case where the patient has died, the needs of the family. The guidance proposes that patient/family narrative or accounts of the events are fed into the investigation, whenever applicable. In the event of a patient death, particular attention with regard to the family, taking account of the emotional state of bereaved relatives and establishing open channels of communication such that the family may indicate if they need bereavement counselling or assistance, is suggested. (NPSA 2009)</p>	<p>5.3.3 NHS Direct</p> <p>The NHS Direct Being Open Policy was supplied to the reviewer. This comprehensive policy document reflects the NPSA Being Open principles and in addition details the process to be followed proportionate to the incident in question. Communication with, and involvement of the patient and/or their family is a key tenet of the policy.</p>	<p>5.4 Sam Morrish investigation review</p> <p>Once it was established that a rapid response referral was not indicated there is evidence that the Patient Safety and Quality Manager, from NHS Devon communicated with Devon Provider Services [DPS], GP Surgery and South Devon Healthcare NHS Foundation Trust [SDHFT] on 18/01/11 by email.</p> <p>The personnel contacted from these agencies follow those names listed in the NHS Devon Incident Reporting Policy. In this correspondence the Patient Safety and Quality Manager outlines that the child death rapid response process has not been initiated and therefore a multi-agency root cause analysis will be undertaken. She outlines that she would like to arrange a RCA meeting where all organisations get together and she states that she is aware that SDHFT, DPS and the GP Surgery are all intending to investigate internally.</p>	<p>A meeting was arranged for 14/03/2011. This meeting did not happen as it was identified that NHS Direct and Devon Doctors personnel needed to be invited. The meeting was rearranged for 04/04/2011.</p>
<p>5.3 Local Guidance and Process</p> <p>5.3.1 South Devon Healthcare Foundation Trust (SDHFT)</p> <p>The reviewer was supplied with the Trust’s Being Open protocol, a document that reflects the NPSA Being</p>	<p>5.3.4 Devon Doctors</p> <p>Devon Doctors supplied a copy of their Incident Reporting Policy; Section 10 of the policy details how patients and/or their relatives will be informed and involved. Consideration to inviting family/carers to a meeting with Devon Doctors to discuss investigation findings is detailed.</p>	<p>It is not clear how all agencies involved in Sam’s care were identified.</p> <p>It is clear that at this stage NHS Direct and Devon Drs were not</p>	<p>Mr Morrish requested copies of voice recordings of the phone calls made to both NHS Direct and Devon Doctors. These were supplied. No offer was made of a health professional or member of staff from either agency to be present when the parents listened to the recordings. Consequently, Mr and Mrs Morrish listened to the recordings on their own. This was reported by Mr and Mrs Morrish as traumatic and it is both dispassionate and inconsiderate that this situation arose.</p>

NHS Direct report being made aware of Sam's death on 31/03/11. NHS Direct were unable to attend the meeting on 04/04/11 due to existing commitments, however, the Chief Executive Officer has apologised to Mr Morrish stating that he sincerely regrets that the meeting was not attended by NHS Direct. Although at the time of the meeting NHS Direct had only been aware of Sam's death for less than a week, he acknowledges that it would have been helpful for all parties to be present. Further apology from NHS Direct is made and can be found in the Organisational Learning — Section 6 of this report.

Devon Drs report being aware of Sam's death on 23/12/10 and commencing their internal investigation in March 2011, having undertaken an initial review of the call slip and outline fact finding [email correspondence from Devon Drs to Mr Morrish 23/06/11]. There is no evidence of proactive involvement of the family in the investigation process and therefore there was a missed opportunity in securing factual information about Sam's care that would have informed their investigation. Devon Drs was in attendance at the meeting on 04/04/11. Acknowledgement is made by Devon Drs that their investigation management was not adequate and can be found in the Organisational Learning — Section 6 of this report.

The reviewer is aware that **SDHFT** undertook an internal RCA investigation and a report was produced. The Paediatrician had been in contact with Mr and Mrs Morrish and it is clear that the issues raised at those meetings informed the SDHFT investigation

process. SDHFT was in attendance at the meeting on 04/04/11. Acknowledgement that the investigation processes; Child Death Review Process and links with investigations being conducted by other agencies, did not run as well as SDHFT would expect is made and can be found in the Organisational Learning — Section 6 of this report.

The **GP Surgery** report reviewing the care provided to Sam and learning points were summarised and submitted to NHS Devon on 31/05/11. The GP Surgery did involve the family in their review of Sam's care. A GP was in attendance at the meeting on 04/04/11.

NHS Devon convened the meeting and it was chaired by the Patient Safety and Quality Manager. There is no evidence that Mr and Mrs Morrish were involved in the investigation process. It is noted however, that NHS Devon report agreement reached with the Paediatrician and the GP "that both would continue to liaise and communicate with Sam's parents and that the GP would feed back specifically from the RCA with support from the RCA lead" (answers to questions posed by family and reviewer). Furthermore, NHS Devon articulate acknowledgement of a need for there to be more direct and inclusive liaison by the RCA lead as well as the clinicians to establish whether families want to be included in the RCA process. Apology and corrective action is described in NHS Devon's submission titled Organisational Learning, found in Section 6 of this report.

Following the meeting on 04/04/2011 it appears that a RCA report was under construction, led by NHS Devon's Patient Safety and Quality Manager. It is

noted that the NHS Direct contribution to the RCA report was delayed as a national peer review process, the IFNR process, was undertaken. NHS Direct has acknowledged that the 9 week process was too long and reports that steps have been taken to ensure that no family will suffer the same delays again (answers to questions posed by family and reviewer).

There is evidence of confusion relating to meetings that occurred as part of the Child Death Review Process, the SDHFT Child Death Review, the RCA Process and the information flow between the meetings.

It is evident that there was a lack of coordination between the agencies with regard to a lead organisation, and lead investigator of the relevant seniority communicating and escalating within the agencies where delays and ambiguity were apparent. NHS Devon has acknowledged that changes need to be made that will ensure subsequent investigations are led by an individual of sufficient seniority proportionate to the level of investigation required and that the RCA process is under review with the help of the Strategic Health Authority.

The production of the RCA Report underwent a number of iterations which is entirely understandable given the number of agencies involved. However, individual organisational 'sign off' is not clear in terms of whether and how it was achieved.

The final report was not clear and was confusing in parts. There was not an end to end chronology with analysis of significant aspects of the care provided to Sam and his family, spanning both the

total patient pathway and organisational boundaries. The report failed to identify the root causes, based on expert clinical opinion regarding the clinical care Sam experienced, and the subsequent care of the family.

There is evidence of poor communication between the organisations and Mr and Mrs Morrish. The tone of some email correspondence in particular is questionable and Mr and Mrs Morrish report "stonewalling" of direct questions which led to them repeatedly asking for answers. In addition Mr and Mrs Morrish report difficulty accessing senior managers and Chief Executives in the organisations when they were not satisfied with the service they were experiencing from that organisation in relation to the investigation. This is particularly in relation to NHS Direct and Devon Doctors.

It is articulated that the intention was for the Patient Safety and Quality Manager and GP to meet with Mr and Mrs Morrish on completion of the report to share the findings.

The meeting was scheduled for 28/06/2011 and included representation from all agencies involved. An independent chair was appointed and following his appraisal of the final report, the meeting was held, and agreement was reached by all parties, including Mr and Mrs Morrish that an independent review of the investigation into Sam's death was appropriate.

5.5 Investigation review – summary findings

The reviewer believes that the root cause analysis was viewed as an end

in itself, rather than a methodology forming part of an investigation where objective critical analysis of fact coupled with learning derived from root cause analysis methodology would provide answers for the family with regard to the clinical care provided to Sam, whilst also providing reassurance that lessons had been learned and corrective action taken. Therefore, the report represents a collation of individual organisation's RCA processes with limited expert clinical opinion spanning the total care pathway.

The investigation failed to actively engage with the family in seeking their partnership and in learning from them with regard to their experiences. There is significant evidence that Mr Morrish, in particular, proffered information that might otherwise not have been considered, and has consistently pursued organisations in order for him to be kept informed of the investigation process in its various stages.

The identification of all agencies involved in Sam's care was delayed. Had the lead investigator discussed Sam's care pathway with the Paediatrician, all agencies would have been identified from the outset.

There appeared to be a lack of priority and urgency from all agencies in completing the investigation in a timely manner. This is suggestive of staff too junior managing the process. Failure of escalation within the organisations led to the process becoming protracted resulting in heightened anxiety and frustration for Mr and Mrs Morrish.

6. Organisational learning

The GP Surgery had already submitted 'Learning Points' at the end of May 2011 but they may wish to review and revise them following the meeting between [the Reviewer], and the GPs.

The other organisations involved in the independent review were given the opportunity to demonstrate the learning they had gained from their analysis of Sam's care, the care of the Morrish family and the RCA Investigation process.

Submissions are below.

6.1 South Devon Healthcare NHS Foundation Trust (SDHFT)

South Devon Health Care Foundation Trust is committed to investigating, listening and learning from all serious incidents that occur within the hospital. In respect of Sam's case, the Trust has undertaken a comprehensive review and has instigated the following changes as outlined below. The Trust believes these measures will help prevent such a tragic case from happening again. The learning and actions taken are summarised as below:

6.1.2 Paediatric early warning score

The tool is designed to improve the recognition of serious illness requiring the involvement of senior members of paediatric and anaesthetic teams.

This tool was being piloted when SM came to the Emergency Department and is now used for all children and young people attending the Emergency Department who are likely to need admission and then throughout their admission helping to detect

deterioration. The score is integrated into the handover of care from the Emergency Department to Louisa Cary Ward, is recorded and communicated on the Ward Patient board at nursing handover and in the doctors' handovers. The use of the tool requires escalation to senior nursing, paediatric and anaesthetic staff who then act as a "Paediatric Emergency Response Team".

6.1.3 Paediatric Sepsis Bundle

Shock is a term given to the cardiovascular dysfunction accompanying infection and is a spectrum ranging from appropriate compensatory changes such as increasing heart rate and respiratory rate, through symptoms and signs indicating that the body's compensatory mechanisms are becoming insufficient to more severe features of shock such as those SM showed shortly before his collapse.

During the time SM was receiving treatment the senior members of paediatric and anaesthetic staff were assessing a number of factors including but not limited to heart rate, respiratory rate, skin perfusion, conscious level, blood gases etc. These assessments led to decisions to increase oxygen flow, give further boluses of saline and following those treatments it was the combined assessment that his condition was stabilised sufficiently that further escalation of treatment with ventilation and inotropic drugs to support cardiovascular function were not required but it was planned that these treatments would be given if further deterioration occurred. Some of his symptoms and signs were consistent with reasonable stability,

e.g. SM's heart rate and blood gases were relatively reassuring until shortly before he collapsed whereas some features including lactate level and urine output were more abnormal. Gauging how much weight to give to these multiple factors, some reassuring, some less so is difficult. The difficulties the treating team faced in deciding whether the treatments SM had received had sufficiently stabilised his condition are being increasingly recognised internationally. A current theme of patient safety work is around the introduction of a 'Sepsis Bundles' to assist with these decisions. The main difference the sepsis bundle will make is to treat as soon as sepsis is suspected. The Paediatric, Anaesthetic and Emergency Department teams are developing a Paediatric Sepsis Bundle to assist with the assessment and management of children with significant infections. This will assist in assessment, management and monitoring response and will specifically prompt early administration of intravenous antibiotics.

6.1.4 Simulation training

Paediatric multi-disciplinary simulation training has been provided in a training centre since February 2010 helping prepare team members to work together effectively to manage children with serious illness and injury. There are advanced plans to introduce simulation in the clinical environment including the Emergency Department that we believe will lead to further improvements in the performance of teams dealing with emergencies. The learning gained from Sam's care has been incorporated into one of the scenarios that will be practiced.

6.1.5 Teaching sessions

Teaching sessions dealing with the advanced management of septic shock have been delivered to a number of staff groups including senior nursing staff and paediatric doctors and will continue to be delivered on a regular basis.

6.1.6 Investigation of a Multi-agency Serious Adverse Events

The processes of the Child Death Review Process and links with investigations being conducted by other agencies/trusts did not run as well as we would expect. A guideline has been written for the Child Health Directorate to improve co-ordination of various processes following any possible future serious adverse events. We believe that better active management of the process will result in improved support and information for families, investigation and analysis of care, links with other internal departments and external agencies and coordination with the child death review process.

6.1.7 Child death review process

The interaction between internal Serious Adverse Event processes and the Child Death Review Process will be discussed at the next Annual Child Death Review Professionals Meeting and with the new Designated Doctor for Child Death who comes into post in September. The Child Death Review Paperwork will be revised and we will ensure that each area, including ICU, will have an up to date Child Death folder detailing pathway and bereavement information, including leaflets for parents.

6.2 GP Surgery

The GP Surgery had previously identified learning points as part of the NHS Devon RCA Process. Learning points were sent to NHS Devon on 31/05/2011.

They are -

6.2.1 "Just in case" antibiotics

We will continue to prescribe in this way where appropriate but will endeavour to give clearer instructions as to when to use the medicine.

6.2.2 Computer records

Selected information on the computer such as Diagnostic labels are made into a heading and highlighted so that they can be located in a summary box. We continually monitor and update our method of clinical data entry and will strive to improve further.

6.2.3 Diagnosis of asthma

This is an individual decision. Our Senior Nurse Practitioner is very experienced in asthma management and had seen Samuel through some of his surgery visits for chest infections. On balance, she preferred not to label Samuel as 'asthmatic' on the basis that he showed no symptoms of asthma when there was no infection present, and so the likelihood of asthma was low. This approach is still consistent with current guidelines.

6.2.4 Diagnosis of pneumonia

In Nov 2009, Samuel was seen in Torbay Hospital and Azithromycin was prescribed on the basis of X-Ray changes in the left, lower zone of

the chest. He was followed up in the Outpatients department in December and examination was reported to be 'entirely normal'. No follow-up X-Ray was requested and no instructions were fed back to the surgery to consider any predisposition to future infections. The episode was not highlighted specifically on the computer as 'pneumonia'.

6.2.5 Experience in the Waiting Room

"How late are they running?" — the touch screen used to book in patient has now been programmed to inform patient if, and by how much, the GP is running late.

6.2.6 Reception is unfriendly

The touch screen is used to avoid queues at the Reception area and allow the Reception staff to be free to do other duties. Messages appear on the screen instructing patients to seek help from the receptionists if problems arise with the book-in process. The original design for the Reception desk was completely "open plan". After a period of time, however, it was decided to enclose the front desk with a glass partition with openings. We have had discussions for some time about re-designing the front desk to try and lose the window barrier and we have been waiting for the arrival of our new Practice Manager to take the project forward. Plans have now been drawn up. We hope that the new design will bring back a more friendly Reception area.

6.2.7 "Need a big sign to let me know I can come and ask for help"

There is an Amscreen on the wall in the waiting area which continuously broadcasts information relating to

health issues. I believe that this is programmable and that we are able to add our own messages. We will attempt to add a message to the effect that, "If anyone in the waiting room requires the assistance of a Receptionist or is worried about the seriousness of their condition, please report to the Front desk" A poster will be placed on the notice-board in the upstairs waiting area with the same information. The screen and poster will not always be visible to everyone seated in the waiting areas but it is hoped that, with the new design of the Reception area, patients will feel able to seek assistance if required.

6.2.8 Check nappy of a febrile child

We are now aware of checking the nappy of an unwell child with a fever, even if they appear adequately hydrated.

6.2.9 Awareness of Strep A infections

There has been a sudden appearance of information from the Health Protection Agency regarding Strep A infections over the winter period. We are now more aware of the increased vigilance for symptoms of septicaemia as well as meningitis and we will keep each other updated as more information arises. Already there are recommendations that will change our current prescribing habits. Penicillin V for 10 days rather than Amoxicillin for 5-7 days is preferred in suspected Streptococcal, upper respiratory infections, and anti-inflammatory drugs such as Ibuprofen are thought to reduce the body's immune response to streptococci and so paracetamol alone for managing the fever is preferred.

6.2.10 More continuity with the same GP

Although it is not always possible, our system prefers patients to have continuity of care. The staff filter appointment requests to: 1) Own GP, 2) GP last seen and 3) Duty Doctor in more urgent cases.

6.2.11 The Surgery was “not aware of their role” after Sam’s death

There is an unwritten system which the surgery has always operated whereby the GP of the patient (or their next of kin) is responsible for getting in touch as soon as is reasonable, either by phone or visit. In this instance direct contact was complicated in the early few days because calls were answered by Samuel’s grandmother and messages were passed on.

The dilemma was whether offering support via the grandparent was sufficient or whether we should have been more proactive with the possible risk of interfering. A lot of time was spent in discussion amongst the doctors and staff about care and support but the lack of personal contact came across as if there was a lack of interest from the surgery. We all feel extremely sorry that the Morrish family felt neglected — the reality could not have been further from the truth.

Having discussed this issue we realise that, as direct personal contact was not made in the early days we could have written and posted a card with condolences. We now have carefully chosen a card for this purpose.

6.2.12 Referral for counselling

Usually the requirement for bereavement counselling is discussed at the bereavement visit and the specific need for support is a very individual choice. [A GP at the Surgery and the Practice Manager], gathered and supplied a list of web links to organisations for supporting parents, children and siblings. It would have been more helpful for the surgery to have had a directory of agencies at the outset to help discussions over the choice, particularly as there was a lengthy delay in providing guidance on this issue.

The situation of a sudden, unexpected child death is, fortunately rare in General Practice. I believe that, following an unexpected death in similar circumstances, a Rapid Response Investigation would be set up and would take on the responsibility for arranging counselling. A decision was made in this case not to initiate the Rapid Response process. It would have been more helpful if information was more freely available between the hospital and the surgery with respect to who was responsible for initiating bereavement support. No assumptions should be made under these circumstances.

6.2.13 Advice on accessing out of hours care

Rather than just telling patients to contact OOH services if their condition deteriorates, it would be helpful to have a card with the relevant emergency OOH numbers which can be given to patients at the time of the consultation.

We have designed such a card with “warning signs and symptoms” on the reverse. As part of the “safety netting”

process of informing patients how to recognise when a condition deteriorates and seek help, it is also necessary to suggest a reasonable time-frame for review if there are continuing concerns. The doctors have discussed the use of Adastra (the information website for Devon Doctors On-call whereby clinical information can be shared) and we will continue to improve our liaison with the OOH services through this facility.

6.3 NHS Direct

The nurse who spoke with Mrs Morrish made errors of judgement in her assessment of Sam’s condition. The impact of this was that the referral that was made to the out-of-hours doctor was a 0 to 6 hours priority rather than a 0 to 2 hours priority. NHS Direct apologises unreservedly for this. This reinforces the importance that must be attributed to past medical history, recent access to health care for the same or similar symptoms and continuing parental concern.

Individual learning was identified for the nurse advisor involved and is being managed through a supportive plan. The individual lessons learned have also been shared in an anonymised form with the staff in the wider organisation to ensure that all staff can benefit from them.

The responses provided to Mr and Mrs Morrish when they made contact with NHS Direct were initially unnecessarily delayed, insufficiently comprehensive and clear, and insufficiently co-ordinated with other NHS organisations. As a result of this, the way in which NHS Direct will respond in future to such circumstances has been changed. Investigations

will be more timely, and senior staff within NHS Direct will take a closer role in monitoring and ensuring that responses are timely, comprehensive and clear. NHS Direct would also wish to apologise to Mr and Mrs Morrish for the poor response they have received from NHS Direct since the death of their son.

6.4 Devon Doctors

On the 22nd December we recognise, acknowledge and accept there were serious errors made by Devon Doctors which delayed Sam getting to Torbay Hospital.

We failed to identify the call as an emergency at 21:08 hours or to appreciate the obvious anxiety of the mother and her suggestion that she go direct to A&E. We failed to make it clear when we called Mrs Morrish back at 21:17 hours that the advice to come to Newton Abbot Hospital was not as the result of advice from a doctor. We failed to document the increased urgency of the call and the change of symptoms reported by Mrs M at 21:08 hours, which meant that on arrival at the treatment centre Sam was treated as a routine patient and not urgent.

We recognise that the actual delay experienced by Sam and his parents could have been greater had it not been for the mother bringing to the attention of a passing nurse and the proximity of an ambulance to Newton Abbot Hospital when the doctor called a blue light response.

We accept that we are accountable for these failings and unreservedly apologise for them. We are committed to do all we can to prevent such an occurrence happening again.

There are three main areas of learning
—

- a) The call from Mrs Morrish at 21:08 hours should have been prioritised as an emergency call.

We have placed ‘vomiting coffee granules / black liquid’ in children in our emergency call category.

- b) A lack of consistency in the application of the “call back”-process.

We have redesigned our call back training module and will be rolling this out to every call handler by the 19th October 2011 and to every receptionist and driver who works for Devon Doctors before the 30th November 2011.

- c) We are concerned that our investigation of this serious incident was inadequate. Critically we did not seek to involve the family at the onset. We were not sufficiently critical of our own systems and processes. We have not responded in a sufficiently clear way to the appropriate challenges and questions raised by Mr and Mrs Morrish. Our communication was deficient.

We have taken steps to be informed of all child deaths in the area such that we can determine whether they have had any contact with our service. In the cases where there has been contact we will send a letter of condolence. We will involve families and carers sooner to a much greater extent than in this case in future. The

Head of Governance, Medical Directors and Chief Executive will undertake further training in the management of serious incidents. We will work with NHS Devon to ensure that future serious incidents are managed in a much more collaborative and joined-up manner than sadly has been the case in this instance.

*This is name is given to the process where a patient or carer contacts our service back because they have not yet received clinical advice and our response as an organisation to this request.

6.5 NHS Devon

NHS Devon acknowledges that overall the Root Cause Analysis (RCA) process was not of the usual high standard that is expected and for this we apologise. The organisation has learned considerably from this RCA and a number of actions are now in place when we, NHS Devon, lead an RCA process.

A review of the NHS Devon Serious Incident Requiring Investigation (SIRI) and RCA process is underway with the help of the Strategic Health Authority (SHA) to ensure that in future the process runs more smoothly. This includes clear lines of accountability with respect to NHS Devon leading complex RCA's. In future there will always be senior supervision (managerial and clinical) for all RCAs to ensure issues are suitably escalated and we will continually review the appropriateness of the lead as the RCA develops. Future multi-agency reports will have a clear process for both individual

organisational sign off and Director/ Chief Executive sign off by NHS Devon for overall quality assurance.

NHS Devon recognises that it is imperative that we have a good working relationship with our providers within an arena of mutual trust, transparency and open communication. As part of the SIRI and RCA review process, NHS Devon wishes to develop a Memorandum of Understanding with our providers that reflect partnership working within the RCA process. This is a particularly important learning point for NHS Devon as the delays and confusion around the SM RCA has caused considerable distress to the Mr. and Mrs Morrish and for this we are truly sorry.

As part of the RCA review, NHS Devon will develop a clearer process for ensuring that the relevant organisations are identified as there was some confusion with respect to which organisations involved in the care of SM should be contacted. It was only later in the RCA process, during a meeting with DPS that the Minor Injury Unit, Devon Doctors and NHS Direct involvement came to light. This was compromised further by the operational lead for the investigation missing an email with the relevant information in it. NHS recognises that this was an unacceptable error for which we apologise.

Until recently pre meetings did not form part of the RCA process, however NHS Devon will in future ensure that pre meetings to develop and agree the Terms of Reference are in place.

On reflection NHS Devon feels that there should have been more direct and inclusive liaisons by the RCA lead as well

as the clinicians to establish whether the family wished to be included in the RCA process. NHS Devon will ensure that the RCA lead will be the direct contact with the family unless the family request otherwise and will be advised by them whether they wish to be actively involved with the RCA process and who they would like as their single point of contact (if this differs from the lead).

Some organisations were unable to attend the RCA meeting and therefore there were gaps in the conclusions that we should have picked up in a more robust way. NHS Devon is committed to working with providers to ensure that meetings of this nature are a priority for us all and the most appropriate person is directed by each organisation too attends. Our learning from this is to quickly escalate concern if timely and appropriate attendance is proving difficult. If necessary this will go as far as getting Chief Executive intervention.

NHS Devon failed to ask for all the relevant information prior to the RCA meeting and acknowledges that this was unacceptable and apologises. There was also difficulties in receiving clinical information in a timely way that would additionally inform the RCA. In future NHS Devon would like to agree with the relevant providers, as part of the Memorandum of Understanding that all relevant information including recorded calls and transcripts will form part of a routine request for information sharing in order that a full critical analysis of events can be undertaken.

NHS Devon acknowledges that more could have been done to put questions and challenges into the RCA process. In retrospect there was not enough

independent and/or senior clinical input or senior management at the RCA in order to do this. As a direct result of this NHS Devon is changing the way in which they lead RCAs. Where appropriate there will always be a senior manager and senior clinician leading the RCAs.

In future NHS Devon will ensure that joint RCA reports highlight whether further individual action should be undertaken by the relevant organisation. The joint report did not adequately or appropriately highlight whether there were gaps in care and whether individual actions required further investigation by the employing organisation. Any action plan developed in response to the RCA would need to provide full assurance that all concerns/issues were being addressed.

NHS Devon acknowledges that the RCA report is not clear and is not solely focused on the actual meeting that the provider organisations attended. Additional information after the meeting was included in the report that in retrospect should have been acknowledged as an addendum and there was also confusion with respect to additional required information coming from providers. This led to the report being very lengthy and repetitive with some of the conclusions being lost in the detail. With hindsight this was unacceptable and for this NHS Devon apologises for the distress this has caused to the family. Part of the ongoing review is to ensure that our policies are clear and our paperwork is fit for purpose and that staff leading the process are fully trained and experienced in doing so.

NHS Devon has ensured that further in-house RCA training sessions are planned which are jointly supported and led by the SHA.

7. Recommendations

- a) Bereavement support is discussed with bereaved relatives following patient death with clear communication of who is responsible for arranging onward support. Where organisations have specific bereavement policies or a guideline in place, adherence to the policy is paramount in ensuring effective communication between agencies is successful in securing the appropriate bereavement support for families.
- b) Clarity and improved understanding by health professionals of the Child Death Review Processes and the relationship between Child Death Review Processes and Serious Incident Requiring Investigation [SIRI] processes is vital. It is recommended that a symposium or workshop for all health agencies in the Southwest is held in the autumn.
- c) Action plans should be drawn up for each of the corrective actions outlined in the Organisational Learning summaries. The action plans should include timescales and lead individuals responsible for completing the action. The action plans to be shared with Mr and Mrs Morrish.
- d) A framework for Multi-agency Investigation is developed which states —
 - A multi-agency investigation is chaired/led by a Director
 - Expert clinical opinion is secured
 - All agencies involved provide a Director as a point of contact for multi-agency investigations
 - A lead investigator is appointed with appropriate skills and knowledge in the field of investigation

The lead investigator agrees Terms of Reference for the investigation with all agencies involved and the patient and/or family

The lead investigator determines who will be the single point of contact with the patient and/or relatives in gaining their input to the investigation process. In addition, the single point of contact will ensure the patient and/or family are kept informed of the investigation's progress

The investigation may take account of individual organisation's RCA processes and outcomes, but a variety of investigation tools and techniques will be employed. The RCA process is not considered the sole methodology for the investigation.

- e) A Memorandum of Understanding reflective of the Multi-agency Investigation Framework above is developed and entered into by all healthcare commissioners and providers in the Southwest.
- f) Consideration is given to the Morrish investigation forming a case study for regional and national learning.

8. References

Dineen.M [2002] *Six Steps to Root Cause Analysis*. Consequence, Oxford United Kingdom.

Dictionary [2011] Reference (online). Available at: www.dictionarv.reference.com [Accessed 18/08/11]

HM Government [2010] *Working Together to Safeguard Children — A guide to inter-agency working to safeguard and promote the welfare of children*. Available at: <http://publications.dcsf.gov.uk/default.aspx?PageFunction=productdetails&PageMode=publications&ProductId=DCSF-00305-2010>

IMS International [2009] *Guidance Notes: Root Cause Analysis In RCA Toolkit* Available at: www.nrls.ncsa.nhs.uk/resources/rca-conditions/ [Accessed August 2011].

National Patient Safety Agency [2009] *Being Open. Patient Safety Alert NPSA/2009/PSA003*. Available at: www.nris.npsa.nhs.uk/beingopen/ [Accessed July 2011].

Clinical Case Review References

- ¹ Susanna Morrish narrative account (1 April 2011)
- ² [The First GP]'s statement
- ³ Outpatient clinic letter. Torbay Hospital. 16.11.09.
- ⁴ Spurling GKP et al. Delayed antibiotics for respiratory infections. *Cochrane Database of Systematic reviews* 2007, Issue 3.
- ⁵ NICE Clinical Guideline 69: Prescribing of antibiotics for self-limiting respiratory tract infections in adults and children in primary care

- ⁶ Pandemic H1N1 2009 influenza: Clinical Management Guidelines for Adults and Children. Department of Health October 2009
- ⁷ [The Second GP]'s statement
- ⁸ NICE Clinical Guideline 47: Feverish illness in children — assessment and initial management in children younger than 5 years.
- ⁹ Transcript of audiotape (segB-939304200701a)
- ¹⁰ Appendix 14, page 33, Devon Doctors Internal Investigation reference 2674645
- ¹¹ Transcript of audiotape (Call 4. Call from [Devon Doctors] to Mrs Morrish 221210 21:17)
- ¹² [The Paediatric Registrar]'s statement
- ¹³ Post Mortem Report. 6.5.11.
- ¹⁴ Chuang YY et al. Toxic shock syndrome in children: epidemiology, pathogenesis and management *Paediatr Drugs* 2005;7(1):11-25
- ¹⁵ Letter from the CMO dated 14.12.2010 (Gateway ref number 15295)
- ¹⁶ K Zakikhany et al. Increase in invasive *Streptococcus pyogenes* and *Streptococcus pneumoniae* infections in England, December 2010 to January 2011. *Euro surveill.* 2011;16(5):pii=19785. Published 3.2.2011

Statements

Response to Investigation by Susanna Morrish (28/09/2011)

When I look back on the last 24hrs I had with Sam, I remember fear, anxiety and confusion. Despite an overwhelming feeling that something was really wrong with him, I trusted each of the NHS organisations I came into contact with. As I tried to find help for him, often I felt uncertain and confused by the responses, but I did what I was told.

Mixed in with the overwhelming shock and grief we felt that Sam died remained this confusion. We had so many questions, at that stage not realising the “confounding factors” outlined in this report. Why did the GP send us home? Why wasn’t Sam’s nappy checked? Why didn’t NHS Direct seem concerned about the blood in his vomit? Why were we sent to Newton Abbot by ‘Devon Doctors Out of Hours’ when Sam’s condition seriously deteriorated and why, why, why was a desperately sick child made to sit and wait in a queue once we got there?

Initially we were told there would be an investigation into what happened but it would be confidential, we would never see it. Then after lots and lots of questions and contradictory answers we were told there would be an investigation (the RCA) which we would see eventually. More confusion, how can they write a report without speaking to us? We were there. We know who we spoke to and what happened. I tried to write a brief document to outline our experience; expressing the opinion that Sam’s care was delayed by every organisation he came into contact with. (At that stage we weren’t aware of the full extent of the delay in administration of anti-biotics.)

When the draft of the RCA report came out my comment was completely dismissed. Furthermore none of the questions we had been asking had been addressed. Whole chunks of information were missing or inaccurate, nobody seemed to be asking any questions — let alone trying to find areas for “learning”.

In this context this new investigation is a massive leap forward and is a fairly accurate reflection of the events that happened over the 22/23 December. However, this has only been made possible by the months we spent in meetings, making phone calls and emailing the various organisations involved, prior to this report’s commissioning. The only people trying to piece together the missing pieces of the jigsaw and asking the difficult questions that must be asked if to stop this happening, was us.

We will never know if Sam would have lived, but he was let down by each organisation we turned to for help. In a “race against time”- Sam wasn’t given the chances he needed to survive. I am relieved that the clinical investigation now acknowledges that. it’s now vital that each organisation acknowledges their accountability for what happened, and not only identifies areas for change, but also ensures these changes actually happen.

Response to individual NHS organisations comments in this report

Cricketfield Surgery

I do not doubt the sincerity of [the Second GP]'s apology and appreciate that he has said that he is sorry that he didn’t recognise how ill Sam was. I think it would have been more appropriate for the “organisational learning” points to reflect the learning that has been taken on board now, rather than inserting a

document from the original RCA, where many of the points are not relevant to the clinical picture.

NHS Direct

Although not reflected in this document we have received personal letters of apology for the mistakes made by NHS Direct on the night of 22 December.. The description of the nurse making “errors of judgement” glosses over the fact that I gave specific answers but she recorded the opposite answers in the algorithm, and failed to ask some questions altogether. We only realised this by sitting and listening to the recordings of the phone calls made on the night, which is one of the most painful things we have had to do since Sam died. Why we had to do this for NHS Direct to take our complaints seriously, I don’t understand.

Devon Doctors

I am relieved to receive a full and unreserved apology from Devon Doctors in this report. I also appreciate their use of the word “accountable” which so many NHS organisations seem to be afraid to use. To describe communication before this point as “deficient” is glossing over a relationship with them which was very painful and stressful for us. After our initial meetings, contact with Devon Doctors was characterised by stonewalling, buck-passing and abruptness. All we wanted them to do was to acknowledge the mistakes that were made on the night and that a child vomiting blood should be treated as an emergency. Most of the time we were made to feel that we were in the wrong for pursuing this.

The nature of this investigation, which focuses on the clinical picture, doesn’t probe the service provision failures by Devon Doctors, or by any of the other NHS organisations.

South Devon Healthcare Trust

South Devon Healthcare Trust hasn’t issued us with any apology for the 3 hour delay in administration of antibiotics. The use of the word “regrettable” in this to describe what happened is completely inadequate.

I understand with the ‘Paediatric Sepsis bundle’ steps are being implemented to ensure this doesn’t happen again, but this doesn’t answer the question that remains –”why” the delay. I also don’t feel that significantly probing questions were asked about appropriateness of the course of treatment chosen as Sam’s condition started to deteriorate after 1.45, especially as septic shock is identified at this stage. On a separate note I would like to acknowledge gentleness and compassion of the two nurses who cared for Sam and ourselves.

NHS Devon

To say that the RCA process was not “of the usual high standard” is completely inadequate and fails to reflect the repeated and deeply rooted failure of NHS Devon to hold a multi-agency investigation. NHS Devon completely overlooks the fact that an RCA is supposed to be a tool, not an investigation in its own right. I also don’t feel that the investigation review fully illustrates the struggles we had getting some of the NHS organisations to engage with us and the sheer mental and physical toll our “battle” with the NHS had on us. I also question their ability to hold any of these organisations to account.

Wider concerns

Several wider concerns come out of reading this report and the earlier RCA.

Meningitis and Septicaemia

It was apparent that the GP surgery and NHS Direct were concerned with ruling out meningitis but were not looking for septicaemia. A news release* from Meningitis Research last year stresses that “Ruling out Meningitis does not help patients with Septicaemia”. GPs need to be looking for the warning signs of both conditions —including checking the nappy of a febrile child.

Invasive Strep and it’s relationship to Flu

With every health professional I have spoken to, the opinion has been that Sam developed this invasive Strep infection because he was severely compromised by Flu. [The Consultant Paediatrician reviewer] highlights information from the HPA suggesting that Influenza is a significant risk factor for invasive Group A Strep infection and that occurrences of this are on the increase. What steps have been taken to ensure all health professionals are aware of this (GPs, triaging nurses, staff at NHS Direct?) especially as the 2011 Flu season approaches? What steps are being taken to make frontline carers 0 the parents — aware of this?

Flu jabs for children

As an adult I can walk into a chemist and get a flu jab for £8.99. As it stands unless your child is in a specified “risk group” you can’t offer them that same protection. Sam wasn’t in an “at risk group”: 40% of the 602 flu related deaths last year were not in an “at risk group”. (As it isn’t listed on his death certificate I don’t know if Sam is included in the flu death statistics, even though we have been asking this for over 6 months.) Looking at the relationship between invasive strep and influenza, getting a flu jab

is about a lot more than avoiding a “nasty cold”. So why can’t people have the choice to immunise their children if they want to?

Response to Investigation by Mr S Morrish

Introduction

I had promised to outline the questions that we feel have not been answered ahead of the meeting of CEO’s on Sept 30 2011. I apologise if changing my plan has caused any problems.

It is a gruelling task, and I feel thoroughly intimidated by the sheer amount of time and effort that is needed to do this.

On top of everything else, re-visiting the various NHS responses to-date, necessitates going through all of the details of Sam’s death, and the NHS’s treatment of us, again and again.

I will respond in full, once I have a better sense of how individual NHS organisations respond, both to this investigation report and also to us.

My experience in the hands of the NHS has been something like torture. That might seem melodramatic, or self-pitying. It is neither: It is fact.

Since Sam died, whilst trying to understand what on earth happened to him, I have experienced blame-shifting, I have been stonewalled, and for large chunks of time, I have been left in a no-mans land, unsure who to turn to for guidance or answers, and unsure about what lies ahead. In some respects that is still true today.

The NHS’s collective organisational failures to spontaneously investigate what happened to my son, and then to my family is outrageous. This failure has ended up constituting a second trauma. I feel the need to explain this: which in itself speaks volumes.

If I believed my experience was unique, I would be doing other things with my time, nine months and one week after Sam died.

Quite intentionally, I am going to write in general terms today, using a broad-brush, with the hope that you start to see through my eyes, rather than continuing to delude yourselves that one day I should see through yours.

Bias?

As Sam's heart-broken father, I fully accept that I will never be anything but biased in my reading of information about the events that led to Sam's unexpected death. I also acknowledge that I am equally biased in my understanding of the way my wife, and I have been treated by the NHS since Sam died. No doubt everybody can agree that this much is true: I am biased.

Less obvious however, is the fact there is an equivalent bias in the views and understandings of all individuals and organisations that we turned to for help on behalf of Sam.

Whilst the NHS is very quick to understand my bias (as Sam's father), it seems blissfully unaware of its own 'bias'.

If there is any truth in what I am writing - you need to be aware of it: it has profound effects and consequences for how the NHS interacts with its patients. It also has profound effects on investigations, understanding, learning and the possibilities for change.

You should consider the idea that bias might be the reason that some bad things keep happening.

Preliminary response to the NHS's independent investigation

I welcome the good work that has been done in this independent investigation report. Before it - very little had been established - the wrong

conclusions were being drawn - and many failings were being denied.

Some are still unable to say sorry.

In my view, after everything that we have told you, for SDHCT to state that forgetting to give Sam antibiotics for three hours is 'regrettable' - is extremely disappointing.

Others have made their first proportionate written acknowledgement of their failings to date, most notably the U-turn that Devon Doctors have made. This is appreciated and suggests progress.

Progress in establishing what happened however, does not mean that your tasks are completed. Establishing what happened is one step on a journey. It should have been the easiest one.

I think the clinical picture of Sam's last 24 hours is 80 - 90 % complete now. It should be by now. I think some failures of Service Delivery are still being ignored or overlooked, and I have no idea why. They matter.

I think the understanding and analysis of everything that happened to us after Sam died is patchy. In this case, it is not so much that information is missing. It is more that interpretation is weak.

I think the ineptitude of some of the early investigations needs unpacking. I am confident there is much more to be learned.

On balance, if I try to assimilate all of this information, it feels like we are half way there now - maybe a bit further: 50-60% for the report as a whole.

I realise this is a very crude way of gauging progress, and it might not seem fair, but it serves a purpose. 'Half of the picture' is a quantum leap forward from the 'wrong picture'. I acknowledge that freely, and thank [names of Chief Executive and two reviewers] for this huge leap forward.

But I am genuinely concerned that the NHS will settle for half of the picture.

I want to make it crystal clear that in my view, settling for half of the picture, is the equivalent of settling for half of the truth. The problem with half of the truth is that it can be misleading - it can misinform - and it can actually miss the point.

At this point, [the chief executive's] benchmark of 'reasonableness' seems particularly relevant. My question is who decides what is reasonable? You, with your bias? Me, with mine? This question is pivotal: literally.

Patient safety and quality of care?

Back in May I stumbled across the NHS's own 'Being Open' framework (Issue date: 01 October 2004). It is very good, but it is not being implemented.

More recently I have become interested in the Department of Health's 'An organisation with Memory' (first published 2000). It is also very good. But it has not been understood by any of the NHS organisations that I have dealt with.

There is the Department of Health's 'Building a safer NHS for patients, implementing an organisation with a memory' (which followed in 2004). Again - it is brilliant. And again, depressingly, it is not being implemented.

I was so relieved to find these insightful understandings of the problems that I am experiencing today (2011). And then I clocked the publication dates! I experienced the heaviest sinking feeling: do you have any idea how depressing this is? The problem is not just 'organisational memory': it is also 'organisational learning' and 'organisational intelligence'.

What is it going to take to get the NHS to implement its own good guidelines? Please NHS - don't delude yourselves that yet more guidelines will make any difference at all. You may as well decide to change the colour

schemes in all NHS corridors. You may as well chase shadows.

I am not going to find any consolation in simply knowing that you are all busy doing something. I am looking for you to do the right things - meaningful things - things that will actually make your services better... preferably under your own steam.

I think back over nine months of contact with so many people, at so many levels within the NHS. I can not tell you how many conversations have resulted in people referencing their 'personal learning'. The implied meaning has always been that lessons have been learned, and that mistakes will be less likely to happen again.

The inference is always that people do care, and are affected, and can bring about change. Up to a point this makes sense. But on its own it is not enough. The reality is different. How else can you explain why the NHS is still making so many elemental mistakes? Knowledge that is buried in reports, and policy documents will not help anyone. Sometimes the very people that actually write these 'fine sounding' policies and guidelines - are unable to implement them in person. This is true of some of some of you today. How can that be?

I believe that the culture within the NHS is deeply flawed. The NHS is focused on itself - on its staff - on its systems. It is focused on its processes, paperwork, procedures and protocols.... but not its patients, or its patients' families. I do not believe that more guidelines will, in themselves, make any meaningful difference until the insidious and all pervasive cultural problems that run through the NHS are identified, understood and addressed. If nothing else I say or write makes any sense to you - please get your heads around this. The NFIS's cultural malaise has to be tackled from the top: until it is, little will change. Please transform the culture of your organisations.

Everybody would benefit, and your jobs would be easier.

Broad-brush conclusions...

In order to make my preliminary response to the independent investigation manageable (for me as much as for you), I am not going into much detail about anything here. However I think it is worth outlining some of the other themes that still worry me. So here is a quick look:

I am deeply concerned that the NHS as a whole has proved itself to be unable (or unwilling) to voluntarily conduct meaningful investigations into a ‘Serious Incident Requiring Investigation’.

I am shocked to find no tangible evidence that anyone or any organisation is held to account when errors are made. I fear that a well intentioned no-blame culture has become a fig-leaf for a lack of accountability.

I am struck by the GPs’ failure to identify anything that had gone wrong for Sam on their own. What weight can be attached to any ‘peer group’ internal investigations - in light of this?

I am not convinced that lessons learned from the NHS’s failure to spot how sick Sam really was, are being shared widely enough. We are purportedly heading for a more severe Flu season ahead. Are GPs and / or parents any better informed than they were last year?

I think the Service Delivery aspect of Devon Doctors needs much greater scrutiny, as does its governance.

I am particularly struck by NHS Devon’s failures. They have seemed both spineless and toothless in terms of holding any of the services that they commission to account. Talk of ‘usual high standards’ in their organisational

learning seems misguided. But that might just be my bias?

Regards,

Sam’s Dad.

Independent review — Samuel Morrish — Devon Doctors

Following receipt of the report and the subsequent meeting on 30 September 2011, I would like to make the following comments.

Devon Doctors Ltd. welcomes and accepts the findings and recommendations in the report produced by [names of reviewers].

Page 30. 3.8.1. This paragraph relates to NHS Direct although the reference (10) relates to Devon Doctors Ltd. I confirm that Devon Doctors Ltd. has placed “vomiting black/brown coffee granules in a child” as an emergency disposition, indicating that an ambulance needs to be called immediately.

As an organisation we feel that there is unresolved closure with the parents and are reliant on those who are continuing to meet with Scott and Sue to inform us if there are unresolved issues from a Devon Doctors perspective. We would be happy to meet with the parents if this is felt appropriate.

Finally I would like to thank you and all of those involved in the review in what has been a very difficult time for all, particularly for Scott, Sue and Sam’s brother.

[Initials of]

Chief Executive

Independent review — Samuel Morrish — South Devon Healthcare NHS Foundation Trust

At the outset we would like to say to Mr and Mrs Morrish how sorry we are for the failures identified in the care we gave to Samuel and the on-going after care to the family. We have undertaken a full investigation into the care we delivered and have identified a number of learning points. All of these have already been actioned and we have ongoing audit to give us the assurances the improvements are reliable and embedded in day to day clinical practice. We are fully supportive of these actions and our progress being shared with Samuel’s parents.

In addition we accept the findings of the independent review and the recommendations outlined in section 7, and commit as an organisation to working alongside our NHS partners to improve the cross organisation care we give the population we serve.

[Initials of]

Director of Nursing and Governance / Deputy Chief Executive

Independent review — Samuel Morrish — NHS Devon

As Chief Executive of NHS Devon I take my responsibility to patients and their relatives very seriously indeed. While this means that I am often extremely proud of the way the standards of care we offer, and the way we perform as a service, occasionally I am not. This is such a time.

I have no hesitation in expressing my sorrow to you; the quality of the investigation into the events surrounding your son’s death - and the subsequent report — was completely unacceptable. You should not have had to have gone through what you did.

I can only imagine how losing a child must feel. The impact on you personally, and on those around you, would have been devastating. This, I know, was compounded immeasurably by the effect of my organisation carrying out such a poor investigation.

There are no excuses and I am extremely saddened that this happened.

I want to explain the measures we have taken to ensure that no one has to experience the distress you have, simply because of the way in which an investigation has been handled.

As a result of what happened we committed to undertake a ‘root and branch’ review of our processes, taking expert advice from NHS South West, who are accountable to the Department of Health for NHS arrangements in the region.

This review has prompted fundamental changes in our process, improving the way we lead investigations to ensure the very highest standards of diligence and sensitivity for patients and their relatives.

In summary:

- The chief executive will personally oversee the progress and quality of each investigation;
- Reviews will be led by an executive director; either the director of nursing or the medical director;
- All NHS Devon staff involved in reviews will be retrained to take account of the latest investigative techniques and tools;
- All investigation findings will in future be approved by the chief executive of NHS Devon before being read and approved by their counterpart/s in organisations providing treatment;
- All reviews will in future have clear terms of reference and much greater clarity

will be given at the outset of to identify accountability within organisations. A single staff member/contact will also be made available to support the family/Next of Kin through the investigative process.

In practice, every investigation in future will receive the individual attention of senior management and a relevant senior clinician, a nurse, doctor or consultant.

Where organisations fail to meet the terms of reference for a review, or if other problems are identified then the matter will be escalated to the chief executive for their resolution.

This will ensure timeliness, high quality and transparency will be integral to such reviews.

We fully acknowledge that at times in the investigation there was uncertainty between some of the organisations involved in the review. This led to Scott, in particular, feeling as if he had to intervene to ensure that the all relevant information was included in the investigation.

This is unacceptable and as a result we will strengthen our policy, and put into place a memorandum of understanding to ensure that all organisations we investigate abide by the new standards we set.

The memorandum of understanding will ensure effective leadership of the investigation results in a single point of contact and coordination providing family support, communication and information. All such arrangements will be built into contracts to ensure compliance

It will be agreed between all healthcare organisations within Devon and approved by their boards. It will make clear our expectations of healthcare providers and clearly set out each organisation's duty and responsibilities with regard to investigations.

The NHS' Being Open Policy makes clear the responsibilities for involving families in such

investigations and I apologise unreservedly that our actions did not demonstrate best practice. The frustration you felt due to the delays caused by not being involved is unacceptable.

In future the lead investigator will take responsibility for ensuring that all the agencies who provided care are identified and contacted. Where a commissioning organisation, such as NHS Devon, is not leading the investigation, assurance will be to the same standard. A timeline or 'road map' will also be developed so that the main parts of an investigation; when it starts, when it will end and all points in between, are clearly defined.

In future all families will be offered the opportunity to be part of the investigation and to have a say over who they wish to be their main point of contact. Where we are not directly leading the investigation we will ensure that all organisations we commission understand their duties.

I turn now to the question of the report you received. It is clear to me that this was not good enough — and caused you further distress.

In future, the lead organisation will make its expectations crystal clear regarding the content and quality of such reports.

All reports will be signed off at director and chief executive level. All action plans developed in response to the investigation will provide full assurance that all issues have been appropriately addressed, and that all recommendations are formulated and acted upon within agreed timescales.

As the chief executive of NHS Devon, the commissioning organisation, I will ensure that:

- A new Policy for reviewing serious incidents and a Memorandum of Understanding is developed and adopted at board level across local services;

- All future action plans arising from investigations are completed within agreed timescales with demonstrable evidence and learning from those involved. This process will be strengthened through the contractual processes;
- To further strengthen accountability Audit South West, an independent auditor will review all action plans arising from investigations, and evidence, to provide assurance of completion;
- Training of staff across organisations to ensure that the new investigations policy is understood;
- With the support of local Chief Executives and in agreement with you we propose to test across the South West whether local policies for reviewing serious incidents provide evidence of timely , high quality investigations within which accountabilities are clear and support to families is provided during these distressing times;
- With the Strategic Health Authority review the Child Death Review process in Devon and Cornwall to ensure that it is better aligned to the SIRI processes in order that issues don't fall between gaps in these two processes.

I hope that I have given you enough detail to allow you to have confidence that I am personally holding each organisation involved, including my own, to account; ensuring accountability is strengthened so that each is clear as to their duties and responsibilities.

This is happening as a direct result of your poor experience.

I again offer you an unreserved apology for the way we let you down at such a distressing time.

I will now do all that I can to ensure that we learn from this terribly sad situation.

[Initials of]

Chief Executive

Conclusion

The death of any child is difficult, not least for the parents of that child. The case of Samuel Morrish has brought into sharp relief the devastating impact of a child’s death after a short period of illness and the importance of ensuring that parents are fully involved in determining and understanding what happened.

People using the NHS look at it as ‘the NHS’ and expect ‘the system’ to operate as one, ensuring that high quality, safe care is delivered between and across organisations. While each individual organisation may seek to work in the most effective way possible, without a whole system approach, it is too easy for the pathway of care to be compromised and for the system to become difficult to understand and navigate.

When they contacted the NHS, the Morrish family were entrusting it with the care of their son Sam. They believed that in doing so, each part of the health system would operate as one in ensuring that he received the best possible care. This report demonstrates that, sadly, this did not happen.

This report highlights a number of things that went wrong across the system as well as within individual parts of the system. The cause of death and the confounding factors are recorded within this report, but the apparent lack of a ‘whole system’, operating as one, has left a number of questions unanswered, both for Sam’s parents and for the organisations within the system.

While many of the clinical issues have been identified and questions in relation to Sam’s clinical care have been answered, there are a number of service issues that have not been fully addressed through this review and the report includes a number of questions that the organisations should ask themselves.

I am unable to express the level of my respect and admiration for Sam’s parents and the way in which they have conducted themselves throughout this traumatic ordeal. It is clear from their testimony, however, that they have lost considerable confidence in the ability of ‘the system’ to care for children with needs similar to their son’s — and this is regrettable for everyone concerned.

Repairing and rebuilding this trust can be achieved if the whole system, and those operating within it, commit to and follow the ‘Being Open’ framework. This will play a major role in helping to ensure that families are engaged and involved in an open and transparent process that has the desire to learn lessons at the heart of what it does.

I am encouraged by the commitment that has been shown by all of the organisations concerned in this case. Each has acknowledged the shortcomings that have been identified and have displayed a genuine willingness to learn and improve. We should never lose sight of the fact that, although things will inevitably go wrong from time to time, every single part of the NHS is constantly striving to provide the best possible care for people. In the vast majority of cases, this care is of a very high quality. What this report highlights is that, when things do go wrong, we must respond openly, thoroughly, quickly and with the support and involvement of the family concerned.

The changes required will be challenging and will take time to embed, but this report marks an important milestone in improving the quality and safety of the services provided by the local NHS.

[Name of]
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