Incident in West Midlands

Agenda Item 13
Reference: 10B.038

NHS Direct

Board Meeting: 22 March 2010

Summary	In late December 2008 we received a Category C call from an ambulance service about a patient with acute back pain. Following nurse assessment the call was transferred to the local GP OOH service and the patient was admitted to hospital and died early the next morning. The caller was concerned about the call being transferred to NHS Direct from the ambulance service. We subsequently received a complaint from the patient's wife about the call. We then received a request from the Coroner for a copy of our records and these were provided. At the Coroner's Inquest we gave evidence explaining our process for handling Category C calls transferred to us from the ambulance service. Very few questions were asked of us at the inquest and there was no concern raised by the Coroner or any other party regarding our handling of the call. The verdict of the Coroner was a Narrative Verdict and made a passing reference to the fact that we had taken a call.
Issues to be considered	The learning from the internal investigation into this incident and the subsequent Coroner's Inquest findings
Action required	The Board is requested to consider this briefing and note the learning from this case.
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Date prepared	9 March 2010

1. Introduction

This briefing is intended to describe the events leading up to and surrounding the death of a pateint and the subsequent Coroner's Inquest into this death. NHS Direct's interest in this is from when the Category C call was passed to us from the local ambulance service in the late evening before the patient's death in the early hours of the next morning. This briefing sets out the chronology of events, our internal investigation and our participation in and the verdict of the Coroner's Inquest.

2. Chronology

Late in the evening of the 23 December 2008 the wife of a 76 year old man with severe lower back pain called for a 999 ambulance. The West Midlands Ambulance Service gave the call a "Category C" grading, gave advice and closed the call. About 30 minutes later the patient's wife made a second 999 call reporting worsening symptoms. This time the call was passed to us to handle as a "Category C" call.

An NHSD Health Advisor called the patient back, taking key patient information, eliminating emergency symptoms. The advisor, in line with our policy then transferred the call to a nurse advisor. The call was assessed using an appropriate algorithm. The algorithm categorised this as a "GP urgent" call, which should have had a response from the GP OOH Service within one hour. The nurse downgraded this to a 'GP Routine', which should have had a response from the GP Out of Hours service within six hours. The record of the call was then electronically transferred to Wolverhanpton Doctors On Call (WDOC). Recordings of these calls were made.

In spite of receiving the call as 'GP Routine' a GP from WDOC called the patient back within 15 minutes and arranged for him to come into the Out of Hours clinic for a face-to-face assessment. Following this assessment the patient was transferred by ambulance to the Wolverhampton New Cross Hospital to the Emergency Assessment Unit (EAU). Upon arrival at the EAU, at approximately 01:30 24 December 2008, he was triaged and assessed as stable on arrival. Within an hour he was given morphine for pain. Immediately after this his condition deteriorated and his blood pressure dropped significantly. He was stabilised and around 05:30 underwent an emergency scan, which confirmed a leaking Abdominal Aortic Aneurysm. Whilst in the scan suite he deteriorated suddenly again and resuscitation was attempted unsuccessfully and he passed away.

3. Complaint

We received a complaint from the wife of the patient on 28 December 2008, which we investigated thoroughly and upheld on the following basis:

1. During the call the Nurse Advisor had a discussion with the caller regarding appropriate use of 999 ambulance services and was abrupt with the caller; and
2. The correct algorithm was used, but the over-ride from urgent GP to routine GP was deemed to be inappropriate.

Upon receipt of the complaint this was escalated and investigated under our processes for ensuring that complaints and issues are looked into thoroughly. The actions we took as a result of this process include:

1. Further call reviews were undertaken for the members of our staff involved. These did not identify any underlying issues.
2. A learning plan was put in place for the Nursing Advisor at the time, which was completed. The nurse concerned is no longer employed by us – although this move

had nothing to do with the incident. This decision had nothing to do with this incident and she was looking for an alternative position when at the time of this incident).

3. We are looking to tighten the processes to make sure that decisions to recategorise calls from urgent to routine are fully thought through and the reasons for the change are properly documented. It is anticipated that this will be in place from Summer 2010. In the meantime we are advising all relevant staff of the importance of recording a reason for the change.

(Although WDOC responded within the normal timescale for an urgent GP referral it is not thought that this action had an impact on the outcome, but we were unaware of this at the time of responding to the complaint)

4. Legal Proceedings

A two-day inquest was held on the 1 and 2 March 2010. Elaine Collins, our Regional Divisional Nurse for the West Midlands gave evidence for NHS Direct. Elaine was not questioned in detail on the change in categorisation of the call and it was the ambulance service not ourselves who were questioned in detail on the management of "Category C" calls.

Elaine was asked about the actions of the Nurse Advisor and spoke about our investigation process and our learning from the incident. Her openness about our learning from the incident was, in part, the cause of her not being asked any particularly challenging questions by the Coroner, the family or any of the advocates representing the other organisations. The majority of time at the inquest was taken up with evidence from and questioning of hospital staff.

The majority of the questioning at the inquest was for the GP from WDOC and for hospital staff. At the end of the inquest the Coroner gave a narrative verdict, which is provided as the Appendix to this briefing paper. In summary the verdict provided a chronology of events as he determined from the evidence and made a statement that the treagic outcome was unlikely to have been contributed to by any delays in any treatment. No Rule 43 Letters[1] were issued from the Coroner at this inquest.

5. Action

NHS Direct offers its sympathies to the family of the deceased.

Board is invited to consider this briefing and any learning that can be taken from it.

[1] A Rule 43 Letter is a letter from the Coroner to the Chief Executive of an organisation requiring improvement. This is the most serious legal sanction that a Coroner may make directly against an organisation; however, he / she may recommend other legal proceedings to the CPS if deemed appropriate to the case.

6. Appendix. Coroner's Inquest Verdict

Following hearing the evidence and questioning of all the witnesses the Coroner's verdict was a Narrative Verdict[2], as follows:

"Mr Wellesley Lewis died at New Cross hospital, Wolverhampton on 24th December 2008 as a result of a ruptured abdominal aortic aneurysm. During the early evening of the 23rd December, Mr Lewis (who had a history of lower back pain) complained of increasing back pain; his wife rang for an ambulance at 10.24pm and later at 10.50pm. On both occasions the calls were triaged as Category C and a referral was made to NHS Direct. A Nurse Advisor from NHS Direct spoke to both Mr and Mrs Lewis on the telephone shortly afterwards and a decision was made by the Nurse Advisor that Mr Lewis should be referred to the general practitioner service,. This referral was picked up by Wolverhampton Doctors on Call at 11.15pm; following a telephone triage by a doctor from that organisation an appointment was made for Mr Lewis to see him. Mr Lewis was seen by the said doctor between 12.14am and 12.40am on 24 December; the doctor made a clinical finding of a pulsating aorta but was unclear as regards a definite diagnosis. He nevertheless felt that Mr Lewis needed to be seen in hospital. Mr Lewis was then taken to the Emergency Admissions Unit at New Cross Hospital where he arrived at 1.20am. He was triaged by a nurse at 1.30am (priority green) and seen by a doctor at 2.30am whose initial impression was that it was more than likely the he had a disc prolapse than a leaking abdominal aortic aneurysm. Very shortly afterwards, at around 3.00am, Mr Lewis suffered a drop in blood pressure necessitating resuscitation with intravenous fluids; a leaking abdominal aortic aneurysm was then highly suspected and a decision was made by the Surgical Specialist Registrar and Surgical Consultant on call for Mr Lewis to undergo an emergency CT scan in order to clarify the situation. This required making arrangements for a radiographer to work the equipment and to have Mr Lewis transferred to the CT department, a transfer, which required the involvement of hospital porters. From 4.30am four porters of an establishment of eight for that period) were on duty, two of whom were already engaged on a task and two of whom were subsequently diverted to a task described as extremely urgent. Mr Lewis underwent his CT scan sometime between 5.30am and 6.00am; this revealed a leaking abdominal aortic aneurysm with a large retroperitoneal haematoma. Steps were taken to organise a second emergency operating theatre as the first emergency theatre was already in use. Very shortly after his scan and before he could undergo any surgery Mr Lewis suffered a cardiac arrest and died. It is not possible to say, on the balance of probabilities, that an earlier admission to hospital on the night of 23rd/24th December followed by surgery would have affected the eventual outcome."

[2] A narrative verdict is a verdict available to coroners in England and Wales following an inquest. In such a verdict the circumstances of a death are recorded without attributing the cause to a named individual. Narrative verdicts were introduced in 2004