Bite-size Learning

Lessons learnt from an asthma death, William Gray; Being prepared for challenges in Asthma.

Speakers: Lisa Cook

Specialist CYP Asthma Practitioner

7th February 2024

Agenda

Time	Topic
12:30 – 12:35	Welcome and introductions
12:35 – 13:05	Lessons learnt from an asthma death, William Gray; being prepared for challenges in asthma
13:05 – 13:20	Q&As
13:20 – 13:30	Survey

Introduction

- We are:

Surrey Heartlands CYP Asthma Team
'Beating Asthma Together'

Team members are:

Suzanne Bailey – ICS CYP Clinical Respiratory Lead/Senior Specialist CYP Asthma Practitioner – suzanne.bailey5@nhs.net

Specialist CYP Asthma Practitioner – Lisa Cook – lisa.cook40@nhs.net

Project Manager – Hawa Choudhury – hawa.choudhury3@nhs.net

With support from: Charlotte Arnold and Julia Newman – CYP Long Term Conditions Transformation Leads

Keeping an eye on us and the budget are Fiona Whitaker and Kylie Langridge, and we also have support from Nicola Mundy from Surrey County Council

Team email address: syheartlands.childrensasthma@nhs.net

Upcoming Training sessions

Children and Young People's asthma training: Bite sized learning:

This is a series of 5 bite size lunchtime learning sessions from February to March 2024, to focus on the important messages of working with children and young people with asthma.

7th February 12:30-13:30: Lessons learnt from an asthma death, William Gray; Being prepared for challenges in asthma

21st February 12:30-13:30: Lessons learnt from an asthma death, Awaab Ishaak; Impact of poor housing on asthma outcomes

29th February 12:30-13:30: Managing asthma in Teenagers, challenges and potential solutions

6th March 12.30-13.30

13th March 12.30-13.30

Slido

- https://app.sli.do/event/7uMqokETbfape2SYVxfMVE

Lessons learnt from an asthma death, William Gray; Being prepared for challenges in Asthma.

- Examine the case study of William Gray
- Main concerns highlighted in coroner's report
- What can we learn from this?
- What strategies can we put in place to prevent this happening to other children?
- Questions

Boy with severe asthma died after multiple medical failings, inquest rules

A 10-day inquest in Chelmsford identified a string of failings in William Gray's care that amounted to neglect,

Boy, 10, who died from asthma attack was failed by NHS staff even though the risk to his life was 'blatantly obvious', coroner rules

Death of boy, 10, in Essex after asthma attack was avoidable, inquest rules

Coroner finds medical professionals' neglect contributed to death of William Gray at hospital in Southend

William Gray, 10, whose death was 'tragic and avoidable', the coroner, Sonia Hayes, concluded. Photograph: Leigh Day/PA

The death of 10-year-old boy after a severe asthma attack was avoidable and was contributed to by the neglect of healthcare professionals, a coroner has concluded.

William Gray died at Southend University hospital on the 29 May 2021 following a cardiorespiratory arrest due to an acute and severe asthma attack.

The inquest, which took place between 23 October and 3 November at Essex coroner's court, heard that William had a near fatal asthma attack on 27 October 2020 when he was admitted to Southend University hospital for treatment and subsequently discharged four hours later.

The court heard that William's asthma began to worsen in the spring of 2021, and that although his mother, Christine Hui, spoke to his GP he was not referred for further treatment and his medication was not changed. On the night of the fatal attack, he collapsed shortly before paramedics arrived following two 999 calls.

The conclusion of the inquest was

Cardiac Arrest Secondary to Respiratory Arrest
Acute Asthma Secondary to Chronically Very Under controlled Asthma.

William Gray - Prevention of future deaths report - 2023-0511 (judiciary.uk)

Escalation of Events

- Suffered from Asthma and Eczema since the age of two
- No asthma attacks for 3 years
- Parents thought his asthma was well controlled.

27th October 2020

- Life threatening Asthma attack
- Chest compressions, IM Adrenalin and Oxygen therapy
- Discharged from Southend hospital after 4 hours
- No assessment of symptoms or changes to medication

Post discharge

- Family contact their GP
- Referral to Asthma and allergy service chased

4th November 2020

- Follow up by Southend hospital
- Steroid preventer inhaler prescribed

14th November 2020

- **Consultant appointment at Southend hospital**
- **Reviews were telephone calls of no more than 5 minutes**
- **William was not spoken to during these telephone reviews**
- **No contact from asthma and allergy service from 1/2/21- 21/5/21**

Dec 2020-May 2021

- **GP prescribed four short courses of oral steroids Dec, Feb, April, May**
- **Excessive reliever inhaler prescriptions**
- **Absence of ongoing preventer inhaler prescriptions**

21st May 2021

- **Asthma nurse didn't review or escalate the increased saba use**

25th May 2021

- Reviewed by ANP at GP surgery at request of GP following fourth course of steroids
- Asthma remained poorly controlled, concerns not escalated

29th May 2021

- Asthma attack
- 00:18 Ambulance arrives, respiratory arrest, unable to secure airway
- IM adrenaline not administered although he had a strong pulse

29th May 2021

- 00:35 Cardiac arrest, chest compressions commenced
- 00:45 IV adrenaline administered
- Endotracheal tube inserted and medication administered by HEMS
- William sustained a brain injury not compatible with life

Main Concerns of coroner's report

- **"William Gray died as a consequence of failures by healthcare professionals to recognise the severity and frequency of his asthma symptomatology and the consequential risk to his life that was obvious."**
- **"William's death was contributed to by neglect."**
- **"William's death was avoidable."**
- **"There were multiple failures to escalate and treat William's very poorly controlled asthma by healthcare professionals that would and should have saved William's life."**

Missed opportunity by paramedics

- Beneficial effects of the administration of IM adrenalin wasn’t considered.
- Experienced hospital paediatric doctors all gave evidence that they were unaware that administration of intramuscular adrenaline by paramedics is part of the Joint Royal Colleges Ambulances Liaison Committee JRCALC protocol for life-threatening asthma.

- That ambulance crew focused on the airway to exclusion of other treatment options and did not recognise the significant amount of inflation pressures that are required to manage the airway of an asthmatic child in respiratory arrest. Crew were misled in thinking that the airway adjunct equipment was not the correct size as a consequence, and were swapping the adjuncts.

Training for Health care professionals who care for children and young people with asthma is not mandatory

- **National review asthma deaths (2015)**

  "People with asthma should have a structured review by a **healthcare professional with specialist training in asthma**, at least annually."

  https://www.rcplondon.ac.uk/projects/outputs/why-asthma-still-kills

- **Health Services Safety investigations body (2021)**

  Identified the safety risk: "There are no nationally endorsed training packages for healthcare professionals caring for children with asthma."

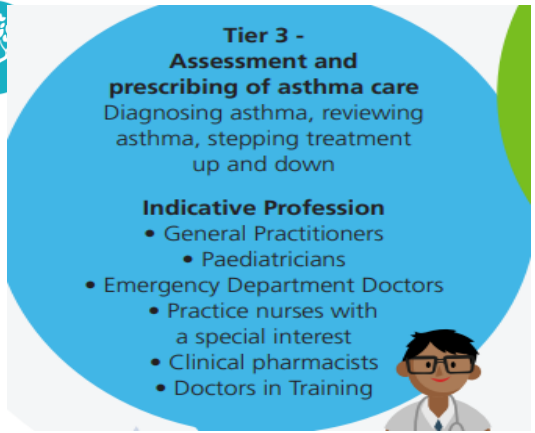
  HSIB recommends that NHS England and NHS Improvement supports clinical experts to work with professional bodies to develop training competencies for healthcare professionals with responsibility for caring for children with suspected or confirmed asthma.

  https://www.hssib.org.uk/patient-safety-investigations/management-of-chronic-asthma-in-children-aged-16-years-and-under/investigation-report/

The National Capabilibties Framework for Professionals who care for Children and Young people with Asthma

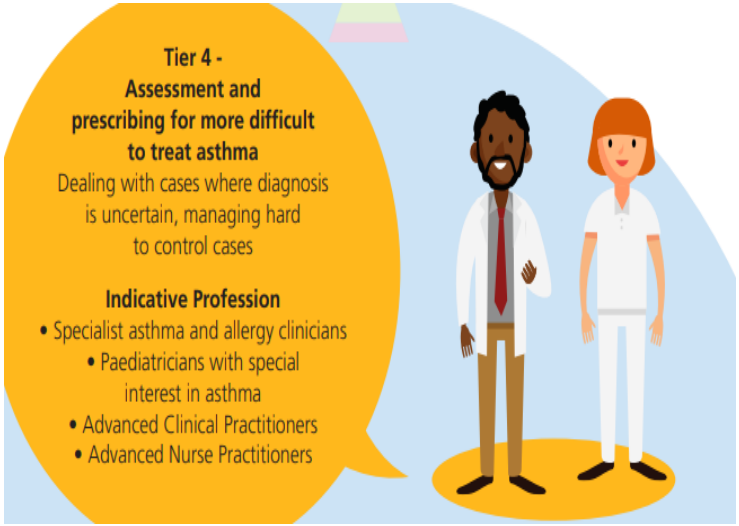
“The development and implementation of the National Capabilities Framework for Professionals who care for Children and Young people with Asthma, aims to ensure that all professionals involved in their care are meeting the level of competency required for their particular role in the management of that child or young person. The adoption of this framework will ensure that competent professionals are delivering effective asthma care and will therefore drive improvements in health outcomes for children and young people with asthma, as well as education and training in the future.”

https://www.e-lfh.org.uk/wp-content/uploads/2022/07/National-Capabilities-Framework.pdf



For primary care clinicians who do regular CYP asthma reviews, tier 3 is recommended: free – online – approx. 8 hours.

Asthma (Children and young people) - elearning for healthcare (e-lfh.org.uk)



Currently there is one course that meets these requirements: The course requires approximately 30 hours of time. You are given 4 months to complete it and it is delivered online. There is a fee of £480.
Advancing Paediatric Asthma Care Course (online) – Rotherham Respiratory LTD

What are the advantages and disadvantages of using telephone calls in children and young people to review their asthma control?

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What are the advantages and disadvantages of using telephone calls in children and young people to review their asthma control?

- Failure to involve child in their care
- Unable to make a full assessment
- Unable to check their understanding
- Unable to check inhaler technique

What were the missed opportunities in this case after William's first asthma attack in 2020?

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What were the missed opportunities in this case after William's first asthma attack in 2020?

- What was the follow up after his first asthma attack?
- British Thoracic society (2019) state

"It is essential that the patient's primary care practice is informed within 24 hours of discharge from the emergency department or hospital following an asthma attack. Ideally this communication should be directly with a named individual responsible for asthma care within the practice"

- Does this happen? How does it happen? Is it on the discharge letter? Are children and parents and carers advised to book a follow up with a GP?

- Did William have an asthma action plan, did he know what to do and when to seek help?
- Were William's asthma triggers identified?
- What caused the first asthma attack?
- Red flags - repeated use of oral steroids and overusing SABAs
- Do we have alerts on our systems if repeatedly ordering a SABA?
- National Review for Asthma Deaths (2015)

More than 6 SABAs prescribed in a year indicate a high risk for asthma death

- When reviewing patients do we count those prescribed by secondary care, primary care, walk in clinics, borrowed from friends and family?
- Risk stratification: searching for and reviewing high risk patients can help to identify those who we need to prioritise.

Risk Stratification

A search run either on EMIS or SystemOne using the following link: [BeatAsthma+ Guide for EMIS - Clinical Digital Resource Collaborative (cdrc.nhs.uk)]

Criteria:

- Aged 5-18 years
- With or without an asthma diagnosis
- 6 or more SABA in last 12 months
- 2 or more OCS in last 12 months
- 1 or more admission coded as asthma in the last 12 months

ANY QUESTIONS?

Want to know more about children and young people's asthma?

Visit www.healthysurrey.org.uk/asthma

Survey

https://forms.office.com/e/trctfD0zhs