Bawa-Garba case: an objective view on diagnosing group A streptococcal sepsis

Surviving sepsis and improving our timely management of it has been a major focus of our profession in the last two decades. Despite this, in 2011, Jack Adcock died from unrecognised group A streptococcal sepsis. Those individuals at the forefront of his medical care have been cited as providing 'truly exceptionally bad care'.

Group A streptococcal sepsis is a major cause of morbidity and mortality. It is well understood that it can strike quickly and often catastrophically, even in healthy individuals; therefore, these cases are often the focus of inquests and media scrutiny. However, it is often accepted that the course of the disease could not have been prevented, or occasionally the trust involved has accepted liability. To our knowledge, this is the first and 'land mark' case of individuals being prosecuted for such an outcome.

We scrutinised our local data of group A streptococcal bacteraemia from St Thomas' Hospital, a tertiary hospital in central London, between 2014 and 2018. The first point of note is the rarity of the condition, leading of course to a widespread inexperience in making this diagnosis. Over this 4-year period we had in total 39 cases, with 11 that fulfilled criteria for severe sepsis. Five of the cases were paediatric and only two of those were cases of severe sepsis.

All of the cases except one were not suspected as invasive group A streptococcal infection at presentation and were diagnosed subsequently on the basis of a positive blood culture. Six cases were discharged initially and had to be recalled following discovery of the microbe on blood culture.

The most common presenting symptoms or signs were of skin rash, cellulitis or abscess – making up two-thirds of the cohort. The other third included non-specific symptoms of fever and coryza, but also symptoms of respiratory tract infection or gastroenteritis. This led to misdiagnosis on admission and occasionally to antibiotics being withheld (or indeed patients being discharged).

At-risk groups included intravenous drug users, and those with malignancy, diabetes mellitus and pregnancy. There were three deaths – all at extremes of age and with other comorbidities present. All the severe cases progressed rapidly from admission, requiring direct admission to intensive care in those who survived.

If, as our data supports and the literature states, group A streptococcal sepsis is both rare and easily missed we are unclear how clinical staff have been prosecuted for manslaughter. The

death of a child from a condition which was missed is a tragedy. The means to prevent recurrence lie in robust systems and cannot reasonably rely on individuals diagnosing a condition which they will not have seen before and cannot be reasonably expected to reliably recognise.

We do not mean to diminish that in the Jack Adcock case there were likely to have been systemic failings in identifying his sepsis early. However, we want to highlight that in the context of this particular infection, it is often difficult to attribute what is clinical error and what is the significant virulence of an organism that is a relatively rare cause of sepsis and difficult to diagnose.

In our profession we always strive to do better, but occasionally we have to be able to accept that there are certain outcomes that may be beyond our control. If we start a culture of prosecuting or erasing healthcare workers from the medical register when these cases occur, our profession (and the public we serve in turn) will suffer. ■

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