[redacted]

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[redacted]

31-Aug-2016

Mrs Louise Hunt
HM Senior Coroner
Birmingham & Solihull Areas
Coroner's Court
50 Newton Street
Birmingham
B4 6NE

RECEIVED
- 7 SEP 2016

Dear Mrs Hunt

Re: Sydney Mya Neil DOB: 21-Oct-2004 (Deceased 06-Mar-2016)
[redacted]

I am writing in response to your REGULATION 28 REPORT TO PREVENT FUTURE DEATHS relating to the inquest on 15th July 2016 into the death of Sydney Mya Neil.

I will address your concerns regarding the use of suction, oxygen, the level of expertise in GP practices and the availability of equipment to deal with emergency situations.

Following the initial SUDIC case discussion on 10th March 2016 recommendations from [redacted] respiratory consultant at Birmingham Children's Hospital, namely to have continual oxygen saturation readings while nebulising a child, have been incorporated into our protocol for Acute Asthma Management in children. Oxygen is used to nebulise should the oxygen saturation fall below 94% in air (attachment 1).

Following the SUDIC meeting in March the practice carried out a serious case review (attachment 2). The outcomes obtained from this review have all been incorporated into our emergency protocol.

I have obtained advice regarding resuscitation in General Practice.

The Care Quality Commission has recommendations for cardiopulmonary resuscitation (CPR) in GP practices. It states all GP practices must be equipped to deal with a medical emergency and all staff should be suitably trained.

There should be a named resuscitation lead in GP practices (Dr Mathias Sander) to ensure:

1 – The practice has access to resuscitation advice, training and practice.
2 – Quality standards are maintained.
3 – Basic checks of equipment.

It suggests agreed principles for defibrillators, oxygen and oximeters (attachment 3). We have these at the practice.

The CQC also promote the Resuscitation Council UK's list of minimum suggested equipment to support CPR in primary care settings. I enclose a list that the Resuscitation Council suggest (attachment 4). I can confirm the practice has the equipment suggested in place.

We have met with Birmingham South Central CCG and after a detailed significant event analysis they have stated:-
"All organisations providing primary care should also have appropriate equipment and drugs for managing other life-threatening emergencies (e.g. anaphylaxis). The CCG would expect all staff to be trained to deliver basic CPR to patients, to have this training updated on a regular basis and have appropriate protocols in place to deal with such emergencies. **In respect of suction being available, the CCG view would be that there would be no requirement for GP practices to have suction available on a regular basis as the use of such equipment would be extremely rare and it would be difficult for GPs to maintain their competence in using this type of equipment. Similarly the CCG would not expect a GP to be able to intubate a patient or to have the equipment available to undertake this procedure as this would not be within the regular skill set of a GP.** This view is based on the Resuscitation Council (UK) guidance that identifies these equipment and competencies are required for GPs with an extended role in aspects such as urgent and emergency care rather than generic general practice" (attachment 5).
I understand the CCG will be providing its own response to the Regulation 28 Report.

We have taken advice from the Local Medical Committee and General Practice Committee (GPC) of the BMA who commissioned [redacted] who is a senior GP who has held roles including provision of and teaching of immediate care, now known as Pre-Hospital Emergency Medicine and is chair of BASICS Education Ltd, who aim to improve emergency care outside hospital, to comment on the care the Practice provided to Miss Neil and provide his general thoughts on this incident. He states **general practice and general practitioners are not an emergency service..... General practitioners who very, very infrequently have to deal with life threatening emergencies and are neither equipped, contracted nor organised to deliver such team based emergency care.**

Once the problems of skill decay are incorporated into the mix then a decision has to be made on a professional cost benefit analysis of whether it is more appropriate and beneficial to use scarce GP resources being spent repeatedly re-

training for something that they might do once or twice in a lifetime when there is supposed to be paramedic with an assistant, the equipment and an ambulance available within eight minutes better able because of psycho motor freshness to deliver a positive outcome by slick delivery of technical skills (attachment 6).

Consultant respiratory paediatrician [redacted] commented at the inquest (taken from the transcript):-
When you reach the point of cardiac arrest the medicines - you are unable to get the medicine through the normal mechanism of breathing into the lungs. The only effective way of getting medicine in is through a drip; that needs to be in hospital..... even in this scenario when we are at that stage of a cardiac arrest, even if we had performed the resuscitation with a clear airway, the chance of being able to drive oxygen down inside into the lungs properly would have been very difficult.

The Royal College of General Practitioner's Mapping of Quality Standard Indicators (2014) states that for Practice Accreditation (PA) "The provider operates a system to ensure that an appropriate healthcare professional can be contacted promptly in the case of emergency."
Also, "All first contact team members have been trained to recognise and respond appropriately to urgent medical matters. A first contact team member trained to recognise and respond appropriately for basic life support is always available (The Duty Doctor)".
Our practice has this in place.

The Practice has reflected carefully on this incident, and has noted your concerns in your Regulation 28 Report. The Practice has consulted widely to obtain a range of opinion both on the care the Practice provided to Miss Neil, as well as what changes we need to implement to provide an appropriate level of management in a primary care setting so as to ensure patient safety. We believe the steps taken, as noted above, and as directed by experts in the field as well as Organisations overseeing patient care and safety, demonstrate the Practice's due regard of your concerns as well as evidence of our intentions always to provide the best care for our patients.

Assuring you of our full co-operation,

Yours sincerely

[redacted]

MBBS MRCGP