Ma'am

LIME TREE SURGERY

[redacted]

321 High Road
Leytonstone
London
E11 4JT

Tel: 020 8519 9914

[redacted]

10-03-2017

Ms Nadia Persaud
Senior Coroner
Coroner area of East London
Walthamstow Coroners Court
Queens Road
Walthamstow
London
E17 8QP

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Dear Ms Persaud,

Thank you for your letter dated 23.2.2017 in response to my reply to the regulation 28 report you sent me dated 19.12.2016. Thank you also for sending me the CD recording of the inquest to clarify some of evidence presented before you, as I was not present for most of the inquest.

Having listened to the inquest recording I remain concerned about the content of your report dated 19.12.2016.

You have mentioned in your letter to me that *'there was concern in this case in relation to a lack of medical review. I have therefore prepared a report under regulation 28 of the coroners (investigation) regulations 2013'*. The implication is that there is systematic lack of medical review due to lack of GP visits which needs rectifying to prevent future deaths. Your assumption is that the only way to rectify this is to arrange regular GP visits. I have a serious objection to such conclusion. The evidence presented to you does not support this view.

Having listened to the evidence there appears to be a total breakdown of communication between the home and the GP surgery following the new manager taking over, shortly before Mr Hawkins passed away.

The manager states that it can take 2hrs to get through on the phone on a Monday to request a visit. Even if this was the case we have a dedicated safe haven fax machine to receive requests for visits as well as alternative contact numbers. At no point, has she stated that the GP refuses to visit when asked and clinically indicated. I think the failure clearly lies in the management systems in place at the home.

I will take this evidence as feedback from the home of their experience of visit requests. I will therefore conduct a survey of visit requests by the home and seek feedback on how to improve this experience. I will follow this up with designing a new pathway for requesting home visits incorporating and responding to this feedback. I will also monitor home visit requests for a period of time.

You state at 5.1: 'There was no system in place for the regular medical monitoring of residents with the Care Home'

Your question was: 'what systems do you have in place for the medical monitoring of residents?' I replied 'the carers request a visit as and when there are concerns regarding any of the patients. This is the normal majority practice throughout UK General Practice. You also asked if regular visits would be beneficial for patients and I replied yes. I was not asked whether regular visits could have prevented this death or any future deaths.

A visit was requested on 11.3.2016 and the patient died two months later on 12.5.2016 from 1a: congestive heart failure, 1b : Ischaemic Heart Disease and 2: Alzheimer's disease. The reason for the home visit request on 11.3.2016 was due to 'weight loss and medico-legal reasons'. After listening to the evidence it is clear there was no history of symptoms or care records being recorded in his nursing records.

It is well documented in the deceased's GP medical records that he had advanced dementia with incomprehensible and sparse speech (see memory clinic letter dated 6.11.2015). The deceased also had a history of difficulty swallowing caused by the dementia (see Speech and Language Therapy Report dated 15.7.2015). The doctor in question discussed the reason for the visit request on 11.3.2016 with a senior colleague and concluded that the reason for the weight loss is due to advanced dementia and not due to an acute or other chronic illness.

Carers and relatives are always told as a rule and safety measure that if the health of the patient changes or deteriorates to call back and request a visit. Why was there no request for a visit between 11.3.2016 and 11.5.2016 if the deceased was indeed unwell or deteriorating?

The member of staff that the duty doctor spoke to on 11.3.2016 was Lavinia (Carer and Manager at the time). She knew the deceased very well. Why was she not called as a witness? I understand there have been considerable difficulties at the home around this time but these difficulties were not explored?

The level of medical care is only as good as the level of care and knowledge of the patient by the carers. Good GP care cannot be solely in the gift of the GP. The quality of care a GP can administer is highly dependent upon the quality of staff in the care home itself (Gladman, 2010 p.20).[1]

Heart failure is a difficult diagnosis to make clinically in an elderly person[2,3] who is able to give a good history let alone in a patient who lacks communication. There are two possible scenarios to consider in the case of the deceased.

1. The deceased has pre-existing heart failure due to heart disease that was not picked up by the doctors through lack of medical care, examination or home visits.
2. The deceased suffered an acute cardiac event after 11.3.2016 or before 11.5.2016 with sudden deterioration and died.

In scenario 1 the deceased had been visited regularly since his residency at the home in 2010. He has had multiple medical assessments which in hindsight suggests that he could possibly have been suffering from heart failure but not clinically picked up. I was only made aware of the cause of death at the inquest and not had the liberty of reviewing his medical records with that cause of death in mind.

He was visited on 5.6.2015 complaining of a chesty cough. No change in breathing. No respiratory distress. HR 76. Few bibasal crackles. Bilateral oedema. ?pneumonitis. clinically well. Treated with antibiotics. This presentation would be in keeping with heart failure.

Similarly a GP visit on 7.6.2013 when staff were complaining of 'unsteadiness and liable to fall. Not sleeping much and moving around'. On examination he had a normal BP (124/80) with few bibasal crepitations in his chest. Again the chest signs and difficulties sleeping would be compatible with heart failure.

In scenario 2 you could argue that the deceased had no clear evidence of heart disease prior to 11.3.2016 and some evidence to suggest he did not have heart disease.

The deceased had his BP taken 5 times during his stay at the home.

Date	BP	Heart rate/Saturation
11.10.2010	136/69	
25.10.2011	118/68	
10.2.2012	116/66	
7.6.2013	124/80	
9.12.2013	134/63	
5.6.2015		HR 76, O2 Sat: 96%

The above findings indicate that he had a very healthy cardiovascular system. He did however have a chronically low Hb. Last reading 9.9 g/dl on 8.10.2015. Could the anaemia have triggered an acute cardiac event resulting in heart failure prior to his death? On the evening of 11.5.2016 the Home staff did seek advice for penile swelling. Could this have been gross pitting oedema extending to the genitals and sacral oedema as part of congestive heart failure. This finding would have been established at post mortem. So should the carers not have noted that the deceased legs have become more swollen and that he is also having difficulties with his breathing?

In 5.1 you have stated that 'The Care Home Manager confirmed that it could be difficult for medical assessments to be arranged for residents within the home who are unable to attend the surgery'. I have been a GP at Lime Tree Surgery since 1998 and have been looking after the residents of Home since then. I do not recall a single verbal or written comment regarding a GP not visiting a patient at the home. The surgery has had an exceptionally good relationship with the previous manager (Lavinia) who had been at the Home since 1998. Whenever she had any concern about a patient and both the carer and doctor felt that it would be in the best interest of the patient for the doctor to visit then the doctor would always visit. Our relationship was such that she could ask for advice any time or for a visit if there had been any change in the condition of the patient. I understand there have been some changes at the Home recently but there have been no changes in our approach or in the way we respond to visits. Even in the case of the visit request on 11.3.2016, if a visit was medically required it would have taken place. Also, the carers should have subsequently expressed any further concerns that they had regarding the deceased's health if there had been any material changes. It is possible that due to internal issues at the Home, there may have been a breakdown of the normal procedures for documenting and communicating concerns to the doctor regarding a patient's health.

In view of the comments made by the manager I will be responding to these concerns as mentioned earlier.

In 5.2 you have stated that *'Both the GP and Care Home Manager indicated that regular GP reviews (perhaps monthly) within the home, by the GP practice would improve the care provided to residents.'*

There is little to no medical evidence to support this view. The literature describes practice models such as extended service schemes, preferred practice arrangements, multidisciplinary healthcare teams of care homes and regular GP 'surgeries' in care homes. A literature review by Social Care

Institute for Excellence found little robust UK evidence on outcomes from studies comparing these models to usual GP care (SCIE 2013 p3).[4]

The level of care provided to Care Home residents is directly proportional to the level of communication and working relationship between the GP practice and the Care Home.

Positive, close working relationships between care homes and GPs are reported by care home staff, GPs and relatives to be associated with positive outcomes (SCIE 2013, p45).[4] These positive outcomes include higher quality and effectiveness of GP care and also increased confidence in care home staff making better judgements when referring residents to the GP.[4]

Several authors have discussed the importance of managers and staff decisions about residents because "they are with them all the time" (SCIE 2013 p69).[4] One author reports that healthcare for residents will be poor if care home management is poor.[4] In discussing poorly managed homes with not so well trained staff relatives have reported that they, rather than the care staff often notice a change or deterioration in the resident's condition and ask for a GP to be called out (SCIE 2013 p71).[4] Several studies have highlighted the poor quality of medical care for residents to be directly affected by poor judgements, skills, low qualifications, high turnover or staff shortages of care home staff (SCIE 2013 p72).[4]

I believe the deceased's case is a very complex one and your conclusions do not reflect what happened in reality. I also feel your recommendation for regular GP visits although desirable is not based on any sound evidence.

Following the deceased's death, the CCG highlighted to us their concerns about the Home as well as concerns expressed by CQC. They asked the GP to conduct a review of all the residents. Following these concerns several visits have been conducted by me to review all the residents medical care. The first medical review was carried out within 72hrs of Mr Hawkins death and the latest one in November 2016. There were no significant findings or new medical diagnoses following these visits. Significant procedural shortcomings and lack of care records were noted. Some of these related to hospital follow-ups, outstanding bloods results and lack of nursing record keeping. These visits were not directly related to the deceased's death but as a precaution given the concerns expressed by other bodies. I did not mention these visits in the inquest as they were not directly relevant to the death. However, in hindsight given your recommendation perhaps I should have, as no extra clinical benefit was gained by conducting these.

I therefore believe that your recommendation in paragraph 6 is not appropriate.

In paragraph 4 you have stated that a GP visit should have taken place but did not. During the inquest I do not recall you saying that the GP should have visited. In hindsight given that the deceased died of undiagnosed IHD and CCF two months later I agree perhaps the diagnosis may have been picked up if the GP visited. However, given the reason for the home visit request (weight loss in a patient with advanced dementia) I do not feel a home visit was warranted on those grounds and at that time. I agree subsequently there should have been further communication between the home and the surgery regarding the deceased wellbeing. There was none. This aspect needed further scrutiny.

In response to paragraph 7, I cannot see any justifiable action other than to strengthen the lines of communication between the care home staff and the surgery given that you have reported from the new manager difficulties in obtaining GP visits. The GP is the person who is delivering bits of service and the care home manager is the facilitator to ensure the client gets what they have identified they need (SCIE survey, 2013 p12).[5] I can assure you that there will be no difficulties in getting GP home visits. An in-house Significant Event Analysis was conducted on 18.5.2016 following the information

around the deceased's death. This resulted in an even lower threshold for home visit requests from this Home given that the information given on the telephone by carers may not reflect the true health needs of residents.

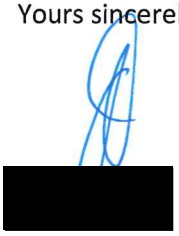
I will also be putting into place the action plan stated above in the paragraph on page 1 in **bold**.

I do not believe the action you propose is likely to prevent future deaths of this kind. There are other factors at play here. There may be other measures that can be more effective and I believe the safeguarding review team have addressed some of those measures. I however, do not have the power over those measures.

Lime Tree Surgery has a very good reputation for providing high quality medical care for all its patients including those residing in care homes despite workload pressures. The actions we have already undertaken confirm and support this. We will continue to consider and implement any new proposed feasible actions if they can be shown to and are likely to improve patient care.

Please do not hesitate to get in touch should you need any further clarification or information.

Yours sincerely,



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