2nd February 2021

This is a response to the Coroner's Regulation 28 report to prevent future deaths ('PFD'), dated 18 September 2020, in respect of the late Pauline Violet Oakley.

May I take this opportunity to again express my condolences to the family and friends of Mrs Oakley, particularly given the sad circumstances surrounding her death and how important it is to ensure measures are taken wherever possible to prevent future similar occurrences.

Understanding the terms of the PFD

Part 5(1) to the PFD relates to the NHS Foundation Trust responsible for Mrs Oakley's discharge home. In this regard, Part 1 to the PFD refers to East London NHS Trust. The Coroner may be assisted to know which organisations/providers various members of the multi-disciplinary teams belong to.

While in hospital, Mrs Oakley was under the care of The Royal London Hospital (Barts Health NHS Trust). Barts Health Trust were responsible for in-patient care and the organisation of safe discharge arrangements including referral to community and social services teams.

The Community Health Service Team (also known as the Extended Primary Care Team) is provided by East London Foundation Trust and includes the Care Navigator, Occupational Therapist, Physiotherapist and District Nurse and Mental Health Nurse.

The Reablement Team (sic) (otherwise known as the Re-enablement Team) to which The Royal London Hospital Social Worker referred Mrs Oakley is run by a team of Occupational Therapists which is part of Tower Hamlets Local Authority/Social Services. The Reablement Team service is used when a patient has ongoing needs to rehabilitate them back to baseline function. Since the inquest I have spoken to the Care Navigator who has confirmed this arrangement is correct.

Mrs Oakley was discharged from hospital with a new care plan/package of social care; therefore, she is likely to have had a Social Worker who would have coordinated this new care package.

Part 5(3) to the PFD relates to East End Homes.

Part 5(2) to the PFD states:

> *There was no assessment of the safety of suitability of Pauline Oakley's flat, or the appliances within the flat, arranged by as part of the Co-ordinate My Care Plan* (sic).

Under correspondence dated 29 December 2020, the Coroner's office clarified the scope of my involvement in the PFD. In addition to the reference to the Co-ordinate My Care Plan, it was stated:

> *As set out in the PFD report, there was no assessment of the safety or suitability of Pauline Oakley's flat, or the appliances within her flat, arranged by the NHS Trust Foundation responsible for her discharge home as part of the hospital discharge plan, and there was no assessment of the safety or suitability of Pauline Oakley's flat, or the appliances within the flat arranged as part of the GP Co-ordinate My Care Plan.*

Further:

> ██████ *gave evidence to the effect that an occupational therapy assessment of Pauline Oakley's home could have been initiated by either her GP or as part of the hospital discharge planning. It appears neither was done.*

Insofar as the PFD (and the email by way of clarification) relates to me / the GP, I respond, respectfully, as follows:

Co-ordinate My Care Plan (https://www.coordinatemycare.co.uk)

The Co-ordinate My Care Urgent Care Plan is a London based initiative. According to its website:

> *Coordinate My Care is a service that coordinates urgent care for patients. It starts with the patients filling in an on line Advance Care Planning questionnaire called myCMC. myCMC then goes to a doctor or nurse who knows the patient who completes the Coordinate My Care (CMC) plan by adding the patients diagnosis, medical details, resuscitation status, medications and recommendations for the urgent care services to follow in an emergency. Once completed the plan is approved and is immediately visible to all the urgent care services including 111, out of hours GPs, the ambulance (in their vehicles) and the emergency departments. This way everyone is in the loop with the patient in the middle.*

The Co-ordinate My Care Plan is a central mode of communication, of a patient's clinical circumstances or needs. It is a good way of communicating with other services. For example, if a paramedic arrives at a property they will have a central record of the patient's clinical picture to refer to.

In respect of my involvement in Ms Oakley's care, in my statement to the coroner of 14 May 2020, I said:

I called Mrs Oakley to review her anticoagulant therapy (apixaban) dose as a comment in the hospital discharge summary suggested the GP should monitor and adjust the dose accordingly. According to her age and current kidney function profile Mrs. Oakley would require 6 monthly monitoring of her kidney function but did not currently have an indication for dose reduction. I asked her about her current social situation as she was living alone during the Covid-19 pandemic. Mrs. Oakley said her carer came every day and had washed and dressed her yesterday. Her pain was controlled. She could take her tablets ok and knew what she had to take. The pharmacy was delivering her medicines. Her sister bought her food and brought it in to her on Mondays. She could call her sister for chats. She lived alone and had a pendant alarm.

In respect of the Co-ordinate My Care Plan, I went on to say:

Mrs Oakley gave consent to share her medical record with the London Ambulance Service using a Co-ordinate My Care plan so that the paramedics would have access to important medical information if she called 999. I wrote and published her Co-ordinate My Care Plan which would be shared with the London Ambulance Service, the palliative care services and GP Out of Hours Service.

The Co-ordinate My Care Plan is focused on appropriate escalation of medical care according to individual patients' medical needs. It is not designed to have any broader role regarding, for example, the fabric of a patient's home environment. Therefore, it would not have played a role in any assessment of the suitability or safety of Mrs Oakley's appliances.

Occupational therapy

In respect of The Royal London Hospital (Barts Health NHS Trust), where Ms Oakley was admitted and discharged, it is usual practice for a patient to be deemed fit from both a medical and social/functional perspective before they are discharged home (the Coroner will no-doubt hear from the relevant Trust in this regard). This would be part of the assessment by the hospital medical team and by a hospital Multi-Disciplinary Team consisting, more likely than not, of an Occupational Therapist, Physiotherapist and Social Worker in order to prepare a hospital discharge plan. The GP (Primary Care Provider) is not involved in hospital discharge planning. However, we would normally receive a discharge summary from the hospital with a brief medical summary, information about medication on discharge, and any medical follow up required.

I mentioned at the Inquest (from speaking to Care Navigator colleagues in the Community Health Service Multi-disciplinary Team before the Inquest) that Mrs Oakley had been discharged by the hospital Social Worker under the care of the Reablement Team (Social Services). I also mentioned at

the Inquest that the people described by the District Nurse as 'carers' were likely to be the Reablement Team – they visit and prompt the patient to support self-care but also have a rehabilitation function over a period of 12 weeks post hospital discharge after which they will make a final assessment of what care is needed at home.

To the best of my knowledge and belief, an Occupational Therapy assessment is a functional assessment (looking, for example, at the need for hand rails or ramps, or having tools in place to help the patient function better or more safely in the home environment). It would not go as far as to assess the safety of electrical appliances, such as the age or adequacy of the electrical heater in this case. Whilst it is correct to say an Occupational Therapy assessment can be initiated by the GP, Mrs Oakley was returning to an integrated, multi-disciplinary umbrella of care, including the Occupational Therapy Reablement Team provided by Tower Hamlets Local Authority/Social Services. Therefore in this scenario there was no further need for a GP referral for an Occupational Therapy assessment to be made as this was already in place.

Going forward

Mrs Oakley was an Integrated Care patient, under the umbrella of a multi-disciplinary team consisting of a central Care Navigator who engages and helps coordinate other care providers, such as the community occupational therapy team, mental health nurses, district nurses, social worker and the general practitioner. Some of this interaction is evidenced in Mrs Oakley's records upon discharge, as per my statement (see reference to Dr ██ and Dr ██ on 1 April 2020).

Since the Inquest, I have attended an Adult Safeguarding webinar (Hoarding and Fire Safety) for Waltham Forest East London CCGs (WEL). At the webinar, I asked who was responsible for ensuring a fire safety check was administered. The response was that Social Services is the lead agency for Health and Safety in the home environment and that, therefore, if Social Services is involved in the patient's care it is their responsibility.

I have discussed this tragic case with the practice clinical team. We all have a duty of care with respect to adult safeguarding when caring for vulnerable patients. In this regard, we are responsible for raising concerns about the adequacy or safety of the home environment to the relevant authorities. Whilst no such concerns were raised with us in this case, the GP practice team has agreed that, in cases like this, where a concern is raised or suspected we will ensure the multi-disciplinary team and Social Services are made aware, especially if they have specific (and relevant) areas of responsibility, such as fire safety risk assessments.

The practice has a longstanding monthly Integrated Care Multidisciplinary Team Meeting which is attended by the Practice GPs, the extended primary care team, the social worker and the palliative care team. We reviewed our practise with regard to concerns about fire safety at the Integrated Care Meeting which immediately followed the Inquest and again at the weekly Practice Meeting on Friday 29th January 2021. It was agreed that Clinicians could prompt the Care Navigator or the Social

Worker at the monthly Integrated Care Multidisciplinary Meeting to ensure that appropriate fire safety checks are implemented.

I have also discussed this case with my appraiser and propose to inform my responsible officer, for any further guidance, and to promote a wider, systemic awareness of the issues in this case.

Do please let me know if you have any questions, or if there is any area or issue you feel I have not addressed.

Dr [redacted]