Greater Manchester
Integrated Care

Stockport Integrated Care Partnership
4th Floor, Stopford House
Piccadilly
Stockport
SK1 3XE

[redacted] [redacted]

Date: 2nd April 2024

[redacted]

[redacted]

Private & Confidential
Ms Alison Mutch
H M Senior Coroner
1 Mount Tabor Street
Stockport
SK1 3XE

Dear Ms Mutch

Inquest into the death of Mr Terence Briney - Date of Death 17 March 2023

I refer to the Regulation 28 Prevention of Future Deaths Report issued following the inquest into the death of the above named. I am sorry to learn of the circumstances of Mr Briney's death and offer my sincere condolences to his family.

You seek assurance in response to the following cause for concern:-

The inquest heard evidence that symptoms raised by Mr Briney and his family were attributed to old age rather than a possible neurological disease. The evidence before the inquest was that there were situations where clinicians would attribute deterioration to the ageing process rather than consider the whole picture and investigate if there was a treatable condition. This presented a risk that treatable conditions in the elderly could be missed.

In order to address this concern we have liaised with Mr Briney's GP and Stockport NHS Foundation Trust (Stepping Hill Hospital).

Mr Briney attended A&E at Stepping Hill Hospital on 19th May 2022 following a fall down a full flight of stairs backwards. He underwent a CT scan of his cervical spine which showed no evidence of acute cervical injury. He also had a CT head which showed no haemorrhages, no space-occupying lesions, and no obstructive hydrocephalic changes. There were generalised involutional changes noted which were put down to chronic small vessel disease. A soft tissue swelling was noted and a right occipital skin discontinuity which was commented on as being a likely post-traumatic laceration. The CT head summary showed 'no evidence of intercranial haemorrhage or recent territorial infarct'

He initially had his wound sutured in A&E and was due to be discharged but experienced a vasovagal episode on return from the toilet following this, and therefore went on to have an ECG, blood tests and a chest x-ray and was referred to the medical team. He was then

admitted under the medical team from 19th May 2022 until 25th May 2022 and the reason for admission on the discharge letter is 'fall with head injury'. His Amlodipine and Diltiazem medications were stopped due to low blood pressure during this admission.

Mr Briney's family believe that Mr Briney health deteriorated following this significant fall in May 2022.

On review of notes, there was no report or documentation of lethargy or tremors when the gentleman presented at the practice or when his family contacted the practice. It was not until Dr Hudson visited the Mr Briney on 15th March 2023 where she noted forearm fasciculations which the family reported had been present for 12 months. This however had not been noted in any previous interactions between Mr Briney and the practice.

Mr Briney's weight loss was first noted in a consultation on the 27th July, when he reported that he had been eating less. It was not discussed again until a consultation on 3rd of February 2023.

[redacted] visited Mr Briney at home on the 15th March at the gentleman's wife's request. His family were very concerned about ongoing weight loss and general deterioration. [redacted] discussed the results of the CT scan with the family which did not show any cancer and that he had a follow-up arranged with [redacted] at Stepping Hill in April. They reported that the previous year he had walked three to four miles but now had very poor mobility within the home. He had a 17kg weight loss. He had difficulty swallowing solids. He had slurred speech. He felt tired all the time and very weak. He had urinary incontinence.

On examination [redacted] found him to be very frail with slurred speech, his blood pressure was slightly low at 101/69, his pulse was 79 bpm regular which is normal, and his temperature was normal at 36.1 degrees. [redacted] observed fasciculations (twitching muscles) in the muscles of his left forearm as he was at rest.

[redacted] decided to admit him acutely under the medical team and wondered whether he may have a neurological condition such as motor neurone disease. [redacted] referred him to the same-day emergency care unit at Stepping Hill and advised he should go in via A&E and his wife agreed to arrange for an ambulance to take him there.

Mr Briney was admitted to Stockport NHS Foundation Trust (Stepping Hill Hospital) on 15 March 2023 following referral by his GP due to a rapid deterioration for the last month; a past medical history was noted as follows:-

- Hypertension
- High lipid level
- Previous history of angina
- Moderate AS
- Recent diagnosis of dysphagia and weight loss of around 14 kg
- Barium swallow 23.2.23: moderate, silent penetration of the airway is seen during swallowing. Marked dysmotility of the oesophagus is noted

Discussion with family highlighted a 12-month history of weight loss with significant muscle waste over the last 6 months. They also raised concern in regard to Mr Briney's swallow ([redacted] had been cutting up her husband's food) following episodes of choking. Regarding the deterioration in mobility if was noted that Mr Briney had attended an evening at the theatre in January 2023 but was now housebound. The family also reported slurred speech and difficulty in understanding what Mr Briney was saying along with fluctuating levels of confusion.

On arrival to the Emergency Department, Mr Briney's observations were stable. His NEWS score was 0 in the ambulance but on arrival scored 1 due to confusion. On examination there was nothing significant apart from the fact that he was dry and looked dehydrated. His neurology examination appeared normal but there was significant muscle waste. Bloods did not raise any concerns for infection.

At this stage there was no clear indication of what had caused the deterioration but the following considerations were noted:-

- Neurological pathway or rapid onset of dementia
- Significant frailty
- Confusion query cause, possibly in the context of rapid onset dementia

At this point further investigations were ordered to be performed including ECG, IV fluid, referral to gastroenterology due to marked oesophageal disability. A SALT review was also requested to evaluate Mr Briney's swallow and a neurology review for clarification of cause of the deterioration.

The following morning it was noted on consultant review that Mr Briney's GCS score had deteriorated and was now 12/15. The working diagnostic was probable vascular dementia. Further investigations were ordered including a CT head and PR examination (which was normal). In view of the pattern of cognitive decline syphilis serology was also requested.

An urgent CT scan was performed and reviewed that day revealing isodense extra -axial collections overlying both cerebral convexities (right more than left). The findings were suggestive of chronic subdural haematoma or subdural hydroma. There was no associated mass-effect. It was advised for neurosurgical team referral.

Advice from the neurological team following review of the CT scan was as follows:-

(1) Bilateral isodence subdural collection - Minimal midline shift
(2) PS3 deterioration (query whether this was new). This referred to baseline of independence and was documented: Confined to bed/chair more than 50% of waking hours

Neurological impression was that it was unlikely that presenting symptoms were unrelated to CT head findings.

The following plan was agreed:-

(1) No need for neurological intervention
(2) Admit locally
(3) Neuro observations
(4) Investigate other causes for deterioration in mobility - if slurred speech is new to rule out stroke
(5) If Mr Binney deteriorates to re-scan and re-discuss
(6) Clear C Spine

Neurological consultant input was agreement that the chronic subdural collection was unlikely to be related to presenting symptoms. No neurological intervention indicated but a plan to re-scan within 2-4 weeks in the event that Mr Briney did not return to his baseline.

Later that night (early hours of 17 March 2023 Mr Briney was reviewed by the on-call doctor due to a sudden deterioration of his saturation. Sats had dropped to 80% with Mr Brinney already on 15L O2 which had not been required previously. Suction was attempted but there was no improvement.

Arterial blood gas revealed further deterioration indicating mixed metabolic and respiratory acidosis with very low pH (7.130) and high CO2 (13.95) and high lactate (3.0).

This was considered to be in keeping with an acute respiratory event, likely from aspiration of own saliva which had been the main concern at the point of admission.

Shortly after this Mr Briney was reviewed further by the on-call Registrar who noted a drop in GCS and hypoxia.

At this stage the Registrar was concerned that this was potentially an NSTEMI, noting the ECG to have revealed a ST depression on the arterial lead. The plan was for treatment for Acute Coronary Syndrome (ACS); there also remained concern re the findings from the CT scan. Mr Briney was prescribed Fondaparinux and aspirin as treatment for ACS.

At 08:30 on 17 March 2023 Mr Briney was reviewed again and further deterioration was noted. Family was contacted and made aware of the significant deterioration and that it was likely that Mr Briney was entering the dying stage.

[redacted], Consultant, reviewed Mr Briney at 09:23 and whilst he was writing his notes, Mr Briney was noted to have sadly passed away.

In light of the Prevention of Future Deaths Report, the GP Partners reviewed Mr Briney's case and discussed if and what could have been done differently. They analysed all of the interactions between Mr Briney and the practice from the point of his discharge from Stepping Hill Hospital on 25 May 2022 (this admission had been due to a fall down a flight of stairs).

They highlighted the consultation on the 3rd February 2023.

Mr Briney attended to see [redacted] with his wife and daughter. There were concerns following his fall in May 2022 and his subsequent decline as outlined below.

- Weakness in hands
- Ongoing dizzy spells and falls
- Reduced appetite
- Weight loss
- Choking on food
- Nausea when eating
- Confusion
- Reduced mobility

At this point his wife was having to fully care for him.

His weight was documented at 57kg, and it was arranged for him to have further bloods and referrals to the dietician/falls team/frailty team. His daughter was advised to contact Adult Social Services for further support.

[redacted] discussed with a colleague (not named in the notes) regarding his choking, weight loss and nausea and the possibility of a gastroscopy was discussed.

During this consultation [redacted] and agreed to make referrals to:

- Dietician
- Falls Team
- Frailty Team
- Upper GI Suspected Cancer Pathway under the two week wait rule.
- Daughter was contacting Adult Social Care and Social Services for support in arranging an attendance allowance.
-

These referrals were processed and sent on the 6th February.

The consensus amongst the GP Partners was that the two week wait referral along with the other referrals to local services were appropriate. These were appropriate referrals given Mr Briney's symptoms, which were suggestive of a possible upper GI cancer.

Given the comments in the Regulation 28 Report: `*The inquest heard evidence that symptoms raised by Mr Briney and his family were attributed to old age rather than a possible neurological disease', t*he GPs discussed whether they would have considered a referral to neurology at this stage. However, on reflection Mr Briney's symptoms were in keeping with a possible upper GI cancer and it was deemed clinically appropriate to exclude cancer first before investigating other referral options.

Whilst it was discussed that perhaps a neurological referral could have been made following the consultation on the 3rd of February, until this point and in the absence of any focal neurological symptoms or specific neurological symptoms such as fasciculation being previously reported to his GP it was always more likely that his symptoms were due to a more prevalent/common pathology, e.g. upper GI cancer as a cause of swallowing problems with weight loss, choking and nausea in an older adult, postural hypotension leading to falls and progressive frailty following falls leading to further functional deterioration in an older patient.

If a neurological referral had been done on 3rd February 2023, it is difficult to be certain if he would have received an appointment by 15th March 2023 given current waiting times of many months, even for urgent referrals.

If he did see a neurologist and had received a neurological diagnosis, Mr Briney and his family could have received information and support. However, it is uncertain whether a referral and diagnosis would have changed the outcome in terms of his prognosis.

The GPs also reflected that here at Cheadle Hulme medical group we operate a principal/personal list and as a practice we strive for continuity of care. It is not always possible and on reflection perhaps if Mr Briney had seen the same clinician on every occasion post his fall in the May 2022 before Dr Hudson visited him at home, it is possible his decline may have been more noticeable.

Since July 2023 we have moved to a total triage model and all medical requests are triaged by a GP who will determine the next course of action thus ensuring continuity care more successfully.

During the reflection process, it was also discussed that although Mr Briney and his family did respond to text messages from the practice, that there could be more consideration to the age of patients who we engage with via text message. Whilst it is common practice for the GPs to discuss with the patients that they are going to send them a text, we should always ensure that they are able and happy to receive and respond using this method of communication.

Having reflected and discussed Mr Briney's presentation, all GPs are now more likely to consider neurological causes for weight loss and swallowing difficulties in older people, alongside the need to rule out cancer, which would always, realistically need to be done first. This consideration to be documented in the notes to aid other clinicians who may see the patient subsequently.

By coming together to review and discuss the circumstances surrounding Mr Briney's case, this has increased the likelihood of GPs considering the possibility of neurological conditions in older people presenting with similar symptoms. It has also facilitated detailed discussion and hence shared learning. However, the partners felt that they would not have acted differently in this case given the symptoms and information available at the time.

From the review of this case, I am satisfied that both the GP Practice and the hospital team did make effort to identify treatable causes for this gentleman's presentation and that appropriate investigations were ordered, and expert advice sought with a view to appropriate treatment. It is acknowledged that the neurological referral could have been made following the GP consultation on 3 February 2023 although it is unclear whether this would have led to an appointment for this gentleman prior to his admission to hospital the following month.

The overall review of this case highlights that communication with the family was not always as timely and I am disappointed to see that family were not contacted overnight on the night of 16 – 17 March 2023 when the significant deterioration in this gentleman's condition occurred as this would have enabled the family to have more time with Mr Briney in the final

hours of his life. I appreciate that we cannot make this right but I would ask that my sincere apologies are conveyed to Mr Briney's family for the delay in contacting them at such an important time.

I hope the above is helpful to you but if you do require any further information please contact [redacted]

Yours sincerely

[redacted]
Deputy Chief Nurse (Quality and Safety)
p.p. on behalf of

[redacted]
Interim Deputy Chief Executive
And Chief Nursing Officer
NHS GM Integrated Care

[redacted]
Placed Based Lead
Greater Manchester Integrated Care