Oakside Surgery

Dr James R Butler
Dr Nick Allison
Dr Duncan Parker

Honicknowle Green Medical Centre
Guy Miles Way
Honicknowle
Plymouth
PL5 3PY

22 August 2014

F.A. O A J Cox
Assistant Coroner
Plymouth, Torbay and South Devon
3 The Crescent
Plymouth
PL1 3AB

Dear A J Cox

Re: Mr Lez Harding 27/08/1956
192 Kings Tamerton Road Kings Tamerton Plymouth PL5 2BS
NHS: 452 703 0035

Thank you for your letter dated 17th of July.

I have now had the chance to read through your report and the concerns you raised.

The paragraphs I have numbered below correspond to those in your Regulation 28 Report with your letter dated 2nd July 2014 on page 3.

The relevant points are detailed below:

1) It was noted that [redacted] took no action during the period from the 18th to 20th September 2013 for which he once again expressed profound regret.

As an individual he has decided to adopt a system used by other members of Staff within the Practice of writing notes to himself using a computer appointment system as well as a ring bound note book.

I did note that Mr Harding was judged to have mental capacity and that he appeared to have made an informed decision in the days leading up to the 18th September 2013 on more than one occasion not to have been admitted to hospital and received what I can consider to be the appropriate treatment. He appears to have made this decision in the knowledge that the outcome could have been fatal.

While this is clearly not an outcome that anyone would have wished for, I did note that it is important that our therapeutic relationship remains advisory and that patients with the appropriate mental capacity are allowed to make decisions which may lead too later harm and might be regarded as decision which do not conform with best medical practice.

I also feel that it would have been inappropriate for [redacted] to have treated Mr Harding as if he had a pulmonary embolism within the community without appropriately investigating it with investigations which were only available within a hospital setting. If he had done so, this would

have raised the possibility of over anti-coagulating him, which could have had equally serious consequences. The only alternative medications available for this (and the one which the medical notes [redacted] was considering) are both unable to be closely monitored and are also irreversible in the event of catastrophic haemorrhage.

2) Having reviewed this case, I am undertaking an audit of all people receiving treatment for pulmonary emboli whether acute or recurrent to ensure that no similar omissions have occurred.

3) As a result of this situation, I have reviewed the advice given to people when they first begin anti-coagulation and as a practice we are in the process of composing a letter informing people of the risks of non-concordance with medication.

   We have also decided to extend this review to patients receiving low molecular rate heparin and novel oral anti-coagulants.

4) I am relatively new to the Practice but my colleagues were able to produce evidence that the situation had been reviewed formally on a number of occasions and now we have your further report I have scheduled a further discussion of the entire case at the next significant event analysis meeting in the Practice which will take place in September 2014.

If you have any further questions then please do not hesitate to contact me.

Yours sincerely

[redacted]