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Basildon Road Surgery
111 Basildon Road
Abbey Wood
London
SE2 0ER
Tel No: 020 8311 3931
Fax: 020 8310 3969

20th June 2014

Dear Dr Harris,

I write further to the regulation 28 report following the inquest concluded on the 7th April 2014 into the death of Lisa Webb who sadly died on the 10th March 2012.

I have considered the concerns set out at section 5 of your report and set out my response below.

I was saddened to learn about Ms Webb's death, I had known her for several years as her GP. I knew that, she was very good at managing her own symptoms of asthma which included an excellent knowledge of how and when to use her inhalers. I was also aware that Ms Webb had suffered with anxiety in the past and had previously been on Citalopram, as recorded in October 2010.

When Ms Webb came to see me on 9th March 2012, I observed that she was breathing fast. This settled as I spoke to her and reassured her.

I took her blood pressure and pulse rate using an Omoron blood pressure monitor. I took Ms Webb's blood pressure twice during the consultation, I recorded that it was 142/72 and this is normal.

The blood pressure monitor showed Ms Webb's pulse rate was normal, I regret that I did not make a record of the pulse rate at the time.

Action: Since Ms Webb's death I make sure that during consultations I check the past history of significant problems and reviews, checks done and review previous consultations. I also check to see if there are any reviews outstanding and either complete them myself or ask the patient to make an appointment at reception for a review. I also record this advice within the patient's electronic record.

I understand that comprehensive medical records are essential for good patient care and I have improved my record keeping and I make more detailed notes.

On the 9th March 2012, I prescribed Ms Webb Diazepam. She came into the consultation and specifically asked for Diazepam. She explained that she thought it would help her anxiety, which I agreed and prescribed it for this reason.

I understand that a dose of between 2 - 5 mg is a relatively low dose and I initially thought that a dose of 2mg, twice per day would be sufficient. Ms Webb indicated that she would rather use ½ a tablet of 5mg Diazepam twice a day which indicated to me, by the way she was explaining how she would use the medication dosage that she had used it before. I was also conscious of the fact that Ms Webb had a large body habitus and I felt that this slightly higher dose would be appropriate in the circumstances. In total she was prescribed a 1 week supply.

At the time I did not know that Ms Webb had sleep Apnoea. She had never indicated any symptoms to suggest that she had this condition and the symptoms she described on the day were not contraindicated with Diazepam.

ACTION: Since this incident I explore more fully all patients' medical histories. I have been reminded that it is important as a GP to ask the patient at the consultation to consider their past conditions which could be relevant to their current symptoms. It is important to combine this with my own knowledge of their medical and the medical notes.

Practice Meeting:

A practice meeting took place on 16th May 2014 with all clinical staff and the Coroners regulation 28 was discussed.

We looked at whether any changes were needed or whether and changes had already been implemented in terms of managing asthma patients.

I also wanted to specifically consider Ms Webb's asthma management. We discussed the fact that I had not been aware that she had not had an asthma review or peak flow done in 2 years.

I confirmed that even though it was the patient's anxiety which was on that occasion causing her breathing difficulties it would have been preferable to have check her peak flow and oxygen saturations. Ideally I should also have reminded her to make an appointment for an asthma review and recorded this advice.

We discussed the importance of monitoring asthma regularly, particularly where a patient is receiving repeat inhalers. As a practice we agreed that regular checks need to be carried out even in circumstances where a patient is very competent in managing their own asthma, as was Ms Webb.

It was agreed that a reminder needed to be issued to all staff about not issuing repeat prescriptions to patients who had outstanding reviews. It was also agreed that reception staff need to be able to offer patients an emergency review so that medication/inhalers can be issued.

The prescription of Diazepam was also discussed at the meeting.

I explained the circumstances of Ms Webb's attendance on the 12th March 2012 and that she had described feeling anxious and that she had specifically asked for Diazepam. I explained that she had indicated some knowledge of this medication and its dosage and felt it would help her symptoms of anxiety.

As I had known Ms Webb for several years and knew that she was good at managing her own and her partner's medical conditions, I felt that a prescription of Diazepam would be appropriate. I explained that following Ms Webb's death it transpired that she had sleep Apnoea. I explained that I would not have issued this medication if I had known this.

In light of this incident we discussed, and I reminded my colleagues, of the importance of asking questions about a patient's history and other symptoms even in circumstances where we feel that we have a good knowledge of the patient. I stressed that this is particularly important when we are prescribing medication.

The importance of good quality record keeping was also discussed by me and the Practice Manager at the meeting on the 16th May 14.

All clinical staff agreed that comprehensive notes need to be made and reviews completed. Staff were reminded to check whether reviews had been completed and to discuss overdue reviews with patients.

It was agreed that in the event reviews cannot be completed during the consultation then patients should be asked to book a review with the appropriate clinician before they leave. We also agreed that this should be recorded within the patients' electronic record.

ACTIONED: A reminder memo has now been provided by the Practice Manager that ALL consultations, change of medications, reminders for overdue review invites must be completed on the screen by all staff.

Conclusion

Since the death of Ms Webb and the subsequent inquest, I now ensure that I check patient reviews are up to date and that their long term conditions are being appropriately managed. I make sure that at each consultation I review their medication and request tests where appropriate.

It has reinforced that good quality care includes following correct guidelines. This incident has also emphasised the importance of keeping up to date with guidelines and to explore with patients their medical symptoms and history, to conduct thorough examinations and check for all possible diagnoses.

It is also important to make good quality comprehensive written notes in the patients' record. Although I have always made good records in the electronic notes I am now more vigilant in recording information given to me by the patient in the consultation, this ensures that the records are more detailed and comprehensive.

I shall continue to keep abreast of the latest guidelines and to maintain and improve my knowledge by continuing my CPD. I have undertaken a number of courses in order to consolidate, update and improve my knowledge in the following areas:

1. **Chronic Obstructive Pulmonary Disease in Primary care – 20/5/12 – Course provider – Doctors.net.uk – CPD = 1.5**

My reflections and learning points for Chronic Obstructive Pulmonary Disease were:

I learned about the relationship of COPD with FEV and the use of FEV measurements regularly.

2. **Shortness of breath – Various aspects of difficulty in breathing – 9/9/12 – Course provider – Doctors.net.uk CPD = 3.00**

My reflections and learning points for Shortness of breath were:

The ways of evaluating shortness of breath and the various aspects of difficulty with breathing.

3. **Paediatric airway problems – 4/8/13 Course provider – Doctors.net.uk – CPD = 1.5**

I have strengthened my awareness and ability to diagnose croup and instituting the treatment. Also remembering to Review the children with severe croup regularly.

I was also updated on the need for IV antibiotics in acute tracheitis.

In this Module of learning I was reminded of the importance of having an emergency injection of Adrenalin available at all times to deal with anaphylaxis.

It also reminded me to suspect a foreign body with an acute onset of respiratory distress and to also suspect foreign body inhalation if a child with no history of asthma who suddenly becomes distressed with breathing. If this is the case then I should immediately give 5 back blows followed by 5 chest blows and then if no response to start resuscitation.

I was also reminded of the importance of keeping Oxygen ready when dealing with any paediatric emergencies with respiratory distress because of Hypoxia and to admit a child with tracheitis for IV antibiotics and possible resuscitation.

4. **Bronchiolitis – Diagnosis & Management – 16/12/13 – Course provider – Doctors.net.uk – CPD = 1.5**

My reflections and learning points for Bronchiolitis were:

The assessment of children with breathlessness should include hydration, Oxygen saturations, feeding pattern. Respiratory rate CRT.

This module also reminded me of the need to avoid routine antibiotics or steroids that are often given by doctors and to remember the emphasis on supportive treatment by explaining to the parent/s to be watchful of any respiratory distress.

I was also updated on the need to admit a child with Bronchiolitis which is more prevalent in the winter months .I was also reminded that the initial presentation can be for coryza and poor feeding which would lead me to check hydration, Oxygen saturation, CRT and to keep other diagnosis such as asthma pneumonia aspiration FB in an acute wheezy child and if the oxygen saturation drops to under 92% and the respiratory rate is over 60 then oxygen is needed and admission to hospital.

I was also reminded to check FH for atopy, asthma and smoking status.

5. Shortness of breath – 9/1/14 – Course provider – Doctors.net.uk – CPD = 1.5

My reflections and learning points for Shortness of breath were:

The differential diagnosis of acute breathlessness in adults such as Asthma, Pneumonia, Chronic obstructive pulmonary disease

I also have an improved knowledge of how to assess acute dyspnoea together with an updated awareness of the Initial management of acute dyspnoea with checking oxygen levels and appearance.

Also an improved awareness of latest guidelines which include checking capillary refill time and oxygen saturation.

I was also reminded of checking with parents on inhaler usage for children and that they are not over indulging with the usage.

I was updated on a reduced respiratory rate may be due to opiates and a normal PCO2 and Oxygen level below 92% is worrying sign in severe asthma and admission maybe needed.

Difficulty in breathing has other causes and Chest x ray and antibiotics are usually not needed routinely and to always Monitor Oxygen in acute cases. The need for referring to secondary care in acute asthma with Oxygen levels of less than 92%.

I was updated on recognising that Difficulty in breathing in malignant chest conditions can be due to other causes like effusion.

6. Paediatric breathing problems – 22/1/14 – course provider – Doctors.net.uk – CPD = 1.00

My reflections and learning points for Paediatric breathing problems were:

The need to assess a child with respiratory distress and if the oxygen saturation is <92% then the child needs oxygen and emergency referral.

Other learning points were not to disturb a child who is drooling and not to examine a child with epiglottis but seek urgent CPR. Also to avoid using a nebuliser in a child under 3 months of age as not

confirmed how the child would react and to seek immediate CPR in a child with silent chest - cyanosis and Oxygen levels < 92%.

I was also reminded of the importance of using the oximeter regularly in any child with respiratory problems and to assess on the basis of information obtained. Also to use oxygen where the oxygen concentration is <92%.

To avoid antibiotics in viral respiratory infection.

7. Obstructive sleep Apnoea – 6/2/14 - Course provider – Doctors.net .uk CPD – 1.5

My Reflections and learning points of Obstructive sleep Apnoea was:

Obstructive sleep apnoea syndrome [OSAS] is the commonest treatable cause of excessive awake time sleepiness

A patient with OSAS can present with change in voice character, severe nasal obstruction, unexplained hoarseness, and dysphagia.

I was updated on the importance of having an increased awareness of the risk factors for Obstructive sleep apnoea such as obesity.

Be familiar with the clinical presentation of OSA and know the appropriate investigations for suspected OSA together with a developed understanding of the management options available for people with OSA ie: how to adapt their sleeping positions, avoid alcohol and sedatives.

I also learned to appreciate the negative outcomes associated with OSA.

To investigate daytime sleepiness by checking CO levels and if any Anaemia.

Detail clinical exam in OSA to include nasal obstruction, hoarseness of voice dysphagia and earlier referral on suspicion of these conditions.

My total CPD hours (including the above) were for **2012** = 57.25 **2013** = 68.5

ACTION: I shall continue to complete CPD courses and modules on all aspects of patient's diseases and medical conditions that I study and complete on Doctors.net.uk which is an interactive online programme of courses.

I hope that this response is of assistance, please do not hesitate to contact me if I can be of any further assistance.

Yours sincerely,

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