WOODLANDS SURGERY

[redacted]

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Dr Karen Henderson
Assistant Coroner
HM Coroner's Court
Station Approach
Woking
Surrey
GU22 7AP

23 September 2014

Dear Dr Henderson,

Miss Clare Serena Anke COOPER
Regulation 28 Report – Action to Prevent Future Deaths

Following the retirement of [redacted] I am now the senior partner at Woodlands Surgery. I was very upset to hear of the death of Miss Cooper and I would like to offer my condolences to her family.

The report from Miss Cooper's inquest on the 11th July 2014 detailed in your letter of the 25th July has been circulated to all of the doctors here at Woodlands Surgery. We have discussed your findings and concerns at great length and have reflected on them both individually and together as a practice.

We noted from your report that the diagnosis of an organic condition was not considered fully enough and that a psychological problem was considered all too readily without proper review of the history that Miss Cooper gave and the results of her blood tests.

Normally at Woodlands Surgery we run personal lists and patients usually see their usual registered doctor. It would appear in this unfortunate case that Miss Cooper saw several doctors and we considered if this lack of continuity of care may have been an issue in why her abnormal blood tests were not followed up and investigated in a more robust way. We agree that consideration of an organic cause of her symptoms should have been given more consideration prior to and following the referral to the eating disorders clinic.

All of the doctors at Woodlands Surgery have reflected on the matters of concern that you raise in your report, please find outlined below the comments from the practice and steps that we have taken in respect to each point of your report which relates to the care covered by the practice.

1. Poor GP documentation

We have all agreed that all consultations should be fully documented in the patients' notes. All patients should have a proper assessment of their history and a full examination should be done and routine vital signs should be recorded if they are clinically relevant.

We have all agreed that the notes keeping in this case should have been better and may have compounded the issue relating to lack of continuity of care. In order to improve patient care and ensure that an episode like this is not repeated, doctors at the practice have agreed that as part of their ongoing personal development plan to submit anonymised consultation notes for their next appraisals. This will give a chance for each individual doctor's appraiser to assess the quality of note keeping.

2. Lack of evidence of a robust assessment of presenting signs and symptoms with a presumption of a psychological/psychiatric problem without considering or excluding an organic cause

Upon reflection all of the doctors have agreed here at the practice that a functional cause was accepted far too readily by the doctors involved in Miss Cooper's care and that an organic cause should have been considered and reconsidered upon subsequent consultations. Miss Cooper's hyponatraemia was dismissed too readily and should have been investigated further.

3. Lack of GP routine vital sign monitoring e.g. heart rate, blood pressure and weight measurement when weight loss is a concern with a lost opportunity to assess the severity of weight loss

We have all agreed that all patients should have a proper assessment of their history and a full examination should be done. Routine vital signs should be recorded if they are clinically relevant. If a patient presents with weight loss then the weight loss needs to be objectively documented with serial weight measurements.

4. No established system for recognition, assessment and management of electrolyte abnormalities within the GP practice and/or consideration of the chemical pathology service to "flag up" particularly concerning results

The system at the practice at the time for identifying abnormal electrolyte results was that all results are seen by the patients' usual registered doctor. It is the responsibility of the patients' usual registered doctor to action and file the results. In relation to this case the results were seen and filed by Miss Cooper's registered doctor. Miss Cooper was reviewed here at the practice within a week of each abnormal electrolyte result. The practice has considered what if any specific changes can be made to the way in which we

handle abnormal pathology results as a result of this case. Unfortunately we do not consider that there are any specific system changes that can be implemented but I have highlighted to all clinicians the importance of monitoring and assessing electrolyte abnormalities and appropriate follow up.

5. Lack of understanding of the underlying causes of hyponatraemia (consistently or intermittently low) and the level below which will require further investigation, and the investigations that should be carried out, particularly in circumstances when there is no obvious cause of the low sodium

We have all discussed at length the causes of hyponatraemia and the investigations required to make a diagnosis of Addison's disease. I am now sure now that all of the doctors here at the practice have a fuller understanding of this rare condition. In addition all of the GPs will now be completing the BMJ online learning e-module on hyponatraemia. We will add this learning need to our PDP's and will be submitting this for our appraisals. We have also invited [redacted] Consultant Endocrinologist at East Surrey Hospital to give a lunchtime educational meeting here at the practice on hyponatraemia and Addison's Disease. This is provisionally booked for Monday 13th October 2014.

6. Insufficiently detailed referral letter to EDS (mentioning "low sodium" but not accompanied with a copy of the blood results) and an opportunity was lost for its significance to be considered

99% of referrals from Woodlands Surgery go to Surrey and Sussex Healthcare Trust (SASH). The Trust is linked in to the pathology software so for the vast majority of our referrals the hospital does have access to our patients' pathology results. However from now on all patient referrals will have copies of all investigations (not just blood tests) attached with them to the referral letter.

9. Lack of hospital or GP notes available for the pathologist undertaking the post mortem to facilitate a greater opportunity for clinic-pathological correlation in deaths which are unascertained and a higher level of suspicion to explore rare causes of unexpected death, especially in the young

GP notes are always available for post mortem examinations. They do need however to be requested from us by the pathologist. Unfortunately the practice did not receive a request on this occasion.

I hope that this response has reassured you that the practice has taken this case and your report very seriously. If you need any further information please do not hesitate to contact me.

Yours sincerely,

[redacted]

Dr Richard Adams