REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] The Lawson Practice 85 Nuttal Street, London N1 5HZ 2. Director, City & Hackney GP Confederation, 85 Nuttall Street, London N1 5HZ
1	**CORONER** I am Jacqueline Devonish, Assistant Coroner for the Coroner area of Inner North London
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 8 January 2015 I commenced an investigation into the death of Viola Burke then aged 80. Viola died on 5 January 2015. The investigation concluded at the end of the inquest on 8 May 2015. The conclusion of the inquest was natural causes. The medical cause of death being valvular heart disease.
4	(1) Viola registered with her GP on 24 April 2014. She had been fitted with a pacemaker and heart valve on 16 May 2014, and has as a result of this made frequent visits to the GP accompanied by her daughter or son. Viola had been prescribed an asthma pump when registered with her previous GP, without a diagnosis of asthma, and without an explanation in the medical records as to the reason for this. (2) On 4 January 2015 she developed a productive cough and was becoming short of breath. For this reason the GP Out of Hours Service, CHUHSE, was contacted by telephone at 20:59 hours. The history given to the service by the daughter included inadequate use of the asthma pump prompted advice on the effective use of this, and a 30 minute call back was made to review the patient condition. Although, the patient was reported as feeling better, a home visit was arranged. (3) The visiting Doctor attended at 23:02 hours and undertook an examination. The previous medical history shared with the attending GP was limited to the information provided by Viola's daughter to CHUHSE and passed on by the referrer. This did not include the pacemaker and valve disease. The daughter was asked for a medication list and was able to provide one. She also mentioned the pacemaker. (4) A diagnosis of chest infection was made and treated. Viola appeared to be responding wetland her daughter left her to go to bed. She checked on Viola sometime between 05:00 and 06:00 hours, and went back to bed until 10:20 hours. (5) On waking on the 5 January 2015 Viola's daughter found her coughing again and so gave her her usual medication and some breakfast, when she collapsed.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In

	my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – (1) In the absence of a diagnosis of asthma, no questions had been asked about the reason for the use of the asthma pump, and it's use became a significant diagnostic tool for the GP Out of Hours Service. (2) The GP practice had implemented a system for care plans to be held by identified vulnerable patients to ensure that the Out of Hours Service had full access to the medical records so as to avoid unnecessary hospital admission. Viola appeared on the GP list of such patients but had no care plan in her possession of the 4 January when the call was made to the CHUHSE. (3) Evidence was given at the inquest that Viola had been sent an invitation letter on 1 October 2014 to attend the surgery for the care plan. When Viola did not respond the GP receptionist is reported to have made three unanswered telephone calls to Viola's landline number. The GP consultation record produced at inquest stated 'Admission avoidance care ended'. The records also showed that Viola attended the surgery with her son on 5 October, and on two further occasions during October on the 11th and 21st. Her daughter is also seen to have telephoned on the 30th. Viola then has eight monitoring entries in November and four in December 2014. At no point was the matter of the Care Plan raised with her. (4) Evidence was given at inquest that the 'Care Plan system' was a Hackney wide initiative implemented in August 2014 by CHUHSE in collaboration with GP practices. The scheme was still in its infancy. The intention was to ensure that the London Ambulance Service and Out of Hours Services would have full access to the patient records of the most vulnerable upon agreement of the patient. Questions were also raised about how the care plan would be kept up to date, and whether the London Ambulance Service would have computerised access to records. Doctors attending Out of Hours operate in a medical vacuum, acting on findings in that moment without access to previous medical history, blood and blood pressure test results.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 22 July 2015. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [redacted] I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your

	response, about the release or the publication of your response by the Chief Coroner.
9	**20 May 2015**