Epsom and St Helier NHS
University Hospitals
NHS Trust

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9 June 2016

Dear Ms Topping

Mr Ernest Higgs (Deceased)
Response to Regulation 28 Report to Prevent Future Deaths

This letter comprises the formal response of Epsom and St. Helier University Hospitals NHS Trust ("the Trust") to the issues raised in the Regulation 28 Report to Prevent Future Deaths, dated 27 April 2016 ("the Report"), made subsequent to the inquest into the death of Ernest Higgs, which was opened on 24 June 2015 and concluded on 7 April 2016. The Trust would like to again express our deepest sympathy and condolences towards the family.

Background

Mr Higgs was an eighty- four year old man who suffered with mild – moderate dysphagia, Parkinson's disease, recurrent aspiration pneumonias, acute renal impairment and advanced small vessel ischaemic disease. Mr Higgs had been a resident at Milner House, (a nursing home in Leatherhead) since September 2014.

On Thursday 15 January 2015 Mr Higgs was seen by a GP at Milner House who diagnosed aspiration pneumonia and prescribed antibiotics and requested that he undergo blood tests. We understand from the Inquest report that the sample bottles and the written consent for the blood test was obtained by Milner House on Friday 16 January 2015 but that the blood samples were not taken until Monday 19 January 2015.

On Monday 19 January 2015, before the blood tests were processed Mr Higgs' condition deteriorated and he was admitted to Epsom Hospital where he was treated for likely aspiration pneumonia with IV antibiotics.

Mr Higgs died at 22:10 on 20 January 2015 on the Buckley Ward of Epsom Hospital.

The Inquest concluded that Mr Higgs died of natural causes as a result of aspiration pneumonia.

The Trust involvement in the inquest was limited to the fact that Mr Higgs died at Epsom Hospital. The Trust was not deemed to be an interested party at the inquest but [redacted] (Foundation Doctor, who no longer works at the Trust) as the Doctor who signed Mr Higgs' death certificate, was asked to attend.

T
he Preventing Future Deaths Report

The Report raises the following concerns:

1. It was clear from the evidence that confusion arose over what advice had been given by the GP on the 15th January 2015. No record was made in the multi-disciplinary notes by the GP of her attendance at Milner House. Care UK, the parent company of Milner House offered to liaise with their local surgeries to ensure the records were made by visiting GPs. However, it appears that the BMA advice to GP's; *'Quality First Managing Workload to Deliver Safer Patient Care'* advises against GP's filling in multi-disciplinary notes. There was no clarity about whose responsibility it was to fill in the notes.

2. Advice given by the GP over the telephone to make Mr Higgs 'nil by mouth' was not recorded and no confirmation of that advice was sent by email. There did not appear to be a safe system in place to ensure telephone advice was accurately sent and received.

3. There was conflicting evidence from Care UK and Epsom Hospital about out of hours provision at the hospital pathology laboratory for community care providers resulting in a significant delay to a diagnostic blood test being undertaken.

Trust response:

The Trust is unable to comment on the first and second concerns raised except to note that whilst Mr Higgs was at Epsom Hospital, on 20 January 2015, [redacted] was approached by one of Mr Higgs' relatives who had concerns that despite Mr Higgs' GP having recently instructed Milner House that Mr Higgs should be nil by mouth and fed by PEG tube they had seen Mr Higgs with half chewed food in his mouth. The following day Dr Wolrich raised a posthumous safeguarding alert in light of this.

In relation to the Coroner's third concern the Trust confirms that there is twenty four hour access to the Trust's pathology department, seven days a week and that the staff at Milner House would have been able to access the out of hours pathology department at Epsom Hospital either via drop off in A and E or by contacting the biochemist on call at any time between 14 and 19 January 2015. The blood results would have been processed within a matter of hours of them being delivered and the results would have been given to whoever was listed as the contact on the request slip which must be provided when the bloods are left with the pathology department.

Whilst all GPs should be aware of the twenty four hour access to the Trust's pathology department, seven days a week, as a reminder, we are including the following statement within the newsletter sent to the GPs within the Trust's catchment area, due to be sent out later this month.

> URGENT ACCESS TO PATHOLOGY OUT-OF-HOURS
> Following the recent death of a patient admitted to Epsom Hospital, we wish to remind all GPs with elderly patients, particularly those in care homes, that there is twenty four hour access to the Trust's pathology department, seven days a week.
>
> On call staff (both medical and technical) can be contacted via the Trust switchboard to arrange analysis. When urgent processing is required, samples should be marked as urgent and dropped off either directly to the lab or out of hours via A and E who will arrange to deliver them to Pathology. In addition to being sent to a patient's GP, the results will also be given by phone to whoever is listed as the contact on the request form.

We will also be sending a letter to each of our three local CCGs requesting that this information is passed on to all registered care homes in their area.

I hope that this letter is of assistance.

Yours sincerely,

CC: [redacted] (Head of Legal Services)

Mr Daniel Elkeles
Chief Executive
Epsom and St. Helier University Hospitals NHS Trust