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Wells Road Surgery
233 Wells Road
Bristol, BS4 2DF

2nd January 2018

Dr Simon Fox, QC
The Coroner's Court
The Courthouse
Old Weston Road
Flax Bourton, BS48 1UL

Dear Dr Fox

Re: Coroner's concerns post-inquest (27/11/17)
Ref No: 01549/2017

I am writing my response regarding your 'Matters Of Concern' from the Regulation 28 Report dated 27th November 2017.

I have attached the report from the practice's Significant Event Analysis (SEA) that took place on Friday 8th December 2017 and will be referring to this report in my responses below.

I shall endeavour to answer each of your concerns below:

1. **The clinical assessment took place in the waiting area, not in a consultation room**

   I was aware Mr Berryman did not see us often regarding medical problems, so I was keen to see him personally. But in view of his refusal of an urgent appointment and reluctance to stay, I saw him at his convenience in the waiting room. I did not want him to leave the surgery without being seen by a doctor, especially before the start of a long Bank Holiday weekend.

   From the SEA meeting, it was noted that Mr Berryman had not requested to see the on-call doctor that day and instead had written a letter requesting antibiotics. Mrs Scally, the receptionist that afternoon, confirmed that Mr Berryman was in fact offered a formal appointment to see the on-call doctor, but he declined this appointment hoping to get antibiotics without seeing a doctor formally.

   As mentioned in inquest statements, Mr Berryman had a frustrating day on Friday 28th April 2017 as he had been back and forth between Lloyds Pharmacy and the surgery twice already because of errors with his Methadone prescription. From the SEA meeting, the first prescription error was when the receptionist gave an unsigned Methadone script to Mr

Berryman. The second-time round, the Methadone prescription issued had not taken into account the upcoming Bank Holiday Monday, so when he came the third time, the prescription issued had to be adjusted to include that, because all pharmacies are closed on Bank Holiday Mondays.

As mentioned in my inquest statements, the on-call doctor reviews urgent patients via a telephone triage appointment system. By 5pm in the afternoon, all urgent appointments would normally be filled, so if someone wishes to see a doctor, they would need to speak to them via telephone triage and then the doctor would decide whether they warrant being seen as an extra. We do not have the capacity as a practice to see patients via open access or as a 'Walk-In', that is why we encourage everyone to ring in the morning to speak to the on-call doctor and get booked into one of the urgent appointment slots that day. Mr Berryman did not call the surgery at all that day requesting an urgent doctor appointment.

If someone does walk in wishing to be seen, my policy is to advise reception to book them in at the end of my session, after urgent 'book on day' patients have been seen. Clearly, if a patient is deemed to be in extremis then they would be seen as an emergency.

On a standard on-call day we have six 'book on day' slots in the morning, six 'book on day' slots in afternoon and six 'book pm' slots in the afternoon.

Our on-call system works like this:

- Practice open 8am and the receptionists start filling the morning book on the day slots.
- Once all the morning book on day slots are filled, all further calls join a telephone triage list for review by the on-call doctor.
- Patients are seen on an appointment basis, but we often receive ad-hoc calls from paramedics or district nurses.
- As we are not a Walk-In Centre or Urgent Care Centre, we do not encourage walk ins and actively encourage patients to call in if they feel unwell, so they can be triaged by the on-call doctor.
- If a patient walks in, the receptionist will ask them why they have come in and use their non-clinical skills to observe how they are. They will then either ring the on-call doctor or knock on their door.
- Once the on-call doctor has seen all the morning book on day patients, they will go down the telephone triage list and either manage patients over the phone or arrange them to come in in the afternoon, using the book pm slots.
- If all the book on day and book pm slots are used up, the doctor can choose to bring the patient in as an extra, but this is done at the doctor's discretion.
- In the afternoon, once all the afternoon book on day and book pm slots are filled, the doctor contacts patients by telephone triage.
- Occasionally a patient will require an urgent home visit and this must be done between seeing patients and telephone triage.

- As well as seeing patients and talking to patients, the on-call doctor may be asked by a nurse to review a patient they are managing, asked by a district nurse to prescribe medications, will be asked to do emergency prescriptions, will be asked by NHS111 to see a patient or asked by the hospital to review a patient after discharge and issue drug or other emergency prescriptions for patients to collect.

But in this case, I saw Mr Berryman between booked urgent patients, rather than at the end of the 'book on day' appointment list because he was reluctant to wait 20-30 minutes.

From the SEA meeting, Mrs Scally confirmed that Mr Berryman refused a formal appointment and she confirmed that she saw me speaking with him in the waiting room. If Mr Berryman had agreed to wait for a formal consultation, then I would have done an appropriate full physical respiratory examination and prescribed him medication based on his presentation. I accept that seeing Mr Berryman in the waiting room was far from an ideal, but I took the opportunity to see a patient, who had not booked or requested a doctor appointment, based on my clinical judgement of the situation

2. No examination of the chest was performed

As mentioned above, the discussion with Mr Berryman was done at his convenience rather than mine based on my clinical judgement of the situation.

The assessment in the waiting room was not a formal consultation. I was able to consult with Mr Berryman informally between urgent booked patients, but the public nature of the waiting room prevented me from doing a physical examination.

During my brief discussion, I was able to get a brief history and observe Mr Berryman's at rest:

- he described a recent onset of a productive irritating cough over the last few days. I recall he mentioned coughing up coloured phlegm, that his breathing seemed a bit worse than normal and he was using his blue inhaler more than normal.
- he appeared to be coughing intermittently; that suggested he had respiratory airways irritation possibly due to an infection;
- assessing his speech. Mr Berryman was able to speak to me in full sentences. A person can be deemed to have acute severe asthma if they have the 'inability to complete sentences in one breath' according to BTS asthma guidelines;
- assess his respiration and respiratory rate. Whilst I do not recall the exact figure for his respiratory rate, I do recall that Mr Berryman was not breathing rapidly at rest and did not appear to be in respiratory distress, meaning he did not appear severely short of breath, did not have rapid shallow breathing, was not tired, drowsy or confused and did not feel faint.

If when I spoke to Mr Berryman he exhibited features suggestive of acute asthma: a fast-respiratory rate and the inability to complete sentences in one breath, then I would have insisted that he stay for a formal consultation and assessment. If at the time of my discussion, I was concerned about Mr Berryman's acute physical health, I would have not hesitated to insist that he stay for a formal examination and would have arranged acute admission to the local hospital for specialist treatment if clinically necessary.

I realise that seeing Mr Berryman at his convenience in the waiting room was not ideal and seeing him there prevented me from doing a formal consultation and full respiratory examination. But he did not present with features of acute severe asthma (as described above) or a severe chest infection (confusion and fast respiratory rate), I used my clinical judgement and I felt that treatment at home with oral antibiotics (Amoxicillin) was appropriate in this situation, but with the follow up advice (which I give to all patients who leave with oral antibiotics), which is: if the patient feels they are deteriorating in their health, they should call (NHS) 111 or if he feels he is having difficulty breathing, then he or a relative should call 999 for emergency admission to hospital.

3. No clinical record was made

As the SEA meeting mentions, Mr Berryman had not requested to see the on-call doctor that day and instead had requested antibiotics via a letter. Mrs Scally made me aware of Mr Berryman's presence in the waiting room by knocking on my consulting room door. At that time I was with a patient booked into an urgent 'book on day' appointment. I advised Mrs Scally to ask Mr Berryman to wait till I had seen all the booked urgent appointments that afternoon, which would have been 20—30 minutes. This request would normally result in the patient being added to the triage list, but when Mrs Scally spoke with Mr Berryman regarding my advice, she came back to me and said he had refused to wait to be seen as he need to get off to the pharmacy. If he had accepted to stay, he would have been booked on the triage list as an extra patient. But since he refused an appointment, his details were not added to the triage list.

After Mr Berryman left, I had proceeded to see the urgent 'book on day' patients that were due to be seen and then had to speak with over a half-dozen patients by telephone triage before the day ended at 6.30pm.

Without the visual reminder of Mr Berryman's name on the triage list, I unfortunately forgot to write up my discussion into his records. I do not believe my failure to write in his records is a general sign of poor organisational skills, rather the lack of a visual reminder on the triage list meant my usual back-up of reviewing the triage list at the end of the on-call shift did not work on this occasion. This is because Mr Berryman was effectively a walk-in patient that did not want to have a formal consultation. Given that we do not provide a walk-in service, our system was not set-up to address this risk.

Upon reflection of this case, I accept that there are several issues that I need to rectify to prevent any future harm to any other patient I see now and in the future.

Primarily the main issue was me seeing a patient in the waiting room and subsequently not being able to examine them properly. I realise that this situation must not happen again. Presently, I have made sure that all medically relevant conversation with a patient occur in my consulting room, so appropriate physical examination can be done in privacy.

Secondly regarding writing in his clinical records;any 'walk-in' patients are now added to the on-call triage list by reception staff in anticipation of a potential assessment by the doctor, whilst the receptionist speaks to the on-call doctor to find out what their advice is. By adding their details to the on-call triage list, there is a visual reminder for both the doctor and receptionist to write any relevant information into the patient records. I want to re-iterate that my failure to write in Mr Berryman's records was not a general sign of poor organisational skills, rather the lack of a visual reminder on the on-call triage list meant my usual back-up review at the end of the on-call shift did not work on this occasion.

I hope this statement covers the 'Matter Of Concern' arising from the Regulation 28 Report and if you have any further questions, please do not hesitate to contact me at the above address.

Yours sincerely