	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Head of GMC Fitness to Practise Team :** practise@gmc-uk.org
1	**CORONER** I am Mrs Heidi Connor, assistant coroner for the coroner area of Nottinghamshire.
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 12 September 2017 I commenced an investigation into the death of Rose Ball, aged 82. The investigation concluded at the end of the inquest on 7 November 2017. The conclusion of the inquest was natural causes.
4	**CIRCUMSTANCES OF THE DEATH** The family asked me to refer to their mother as Rose during the inquest. I reflect that request in this report. <u>Relevant evidence</u> Rose had no significant past medical history relevant to the cause of death. She was not a regular attender at the GP practice, Riverlyn Medical Practice. Bulwell in Nottingham. Rose reported concerns to her GP about pain in her upper tummy and back on 9 June 2016. She was prescribed Lansoprazole and Gaviscon. She confirmed the following day that she felt better. Both of these interactions are clearly recorded as telephone consultations. These records are those of [redacted]. Rose spoke to her GP again on 6 and 7 December 2016. Both of these interactions were with [redacted]. Neither record mentions the fact that these were telephone consultations. In fact, the record of 6 December includes the following : *"Examination : no pain abdomen"* [redacted] prescribed Omeprazole. There is no record of safety-netting advice. There is no record of a plan to see the patient. I did not accept [redacted] explanation for the above record, namely that he was recording the patient's examination of her own abdomen. The following day, Rose's son attended the practice. He begged [redacted] to attend to examine his mother. [redacted] again telephoned her, this time diagnosing a likely upper respiratory tract infection. He prescribed Amoxicillin tablets. There is no record of safety-netting advice or any plan to see or examine the patient. There is no record of routine observations at either appointment – these were clearly impossible as both appointments were by telephone. I found that [redacted] had no plan to examine Rose, despite his assertions to the contrary in court. Sadly, Rose's condition deteriorated. She was admitted to hospital in the early hours of 8 December, and died later that day.

Her cause of death (following a PM) was :

1a Acute peritonitis
1b Perforation of Duodenum
1c Duodenal erosions
2 Ischaemic heart disease

I found that the duodenal perforation is unlikely to have happened before the GP's involvement on 6 and 7 December 2016. I also concluded that it may well be the case that different management by the GP may not have changed the outcome, given Rose's age and co-morbidities.

My focus in drafting this report is on those patients for whom the failure to examine them – and the managing of conditions wholly by telephone – could mean the difference between life and death.

Previous investigations

NHS England

This matter has been the subject of a family complaint. NHS England carried out an independent clinical review into this death and that of her husband just the day before. The entry relevant to this case states :

"With regards to the entry on 7.12.17 [sic] pertaining to Mrs Ball there is very little detail pertaining to the clinical history and no routine observations or clinical findings are recorded…."

It is clear that the reviewer considered [redacted] management on the assumption that the appointment of 7 December was a face to face consultation. The records clearly give that impression.

I was concerned to note also that it appears [redacted] contacted the case handler during the investigation. He is described as "very concerned to outline the good care Mrs Ball was having". I do not know what the protocol is for doctors who are the subject of investigations ringing up to 'put their case' in this way. It would seem that that discussion did not include the fact that the consultations on 6 and 7 December were both by telephone.

[redacted] has subsequently written to NHS England (in a letter dated 20.3.17). In it, he sets out his plan of action for improvements. In the chronology, he does refer to the consultations of 6 and 7 December 2016 as being by telephone. This does not appear to have been picked up on by NHS England.

It may be that NHS England will wish to review this case in light of the evidence of this inquest. They may also wish to re-examine their method of clinical review and consider whether a paper exercise is sufficient in all cases. It is not unreasonable to assume, based solely on the records for these examinations, that they were face to face examinations.

CQC

This practice has been subject to CQC concern. The practice was inspected on 4 January 2017, to follow up a warning notice (issued following an inspection in August 2016). One of the issues identified was systems for managing complaints and significant events.

The practice has recently re-registered – in August 2017. [redacted] gave evidence that he had been told by the CQC that both he and [redacted] need to be registered

	providers before the CQC can carry out its first inspection. The full details of CQC involvement are publically available on their website. I invite the CQC to expedite their inspection of this practice in view of the findings of this inquest.
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. 1. [redacted] failed to record that the consultations of 6 and 7 December were by telephone – and in fact recorded an abdominal examination that never took place. 2. I was troubled by [redacted] evidence in court that he considered his only failing was in relation to record-keeping. 3. It is clear that [redacted] conduct goes well beyond poor record-keeping. I have referred to a pattern of diagnoses by telephone by this practice. I hold records from January 2015 onwards only. It is possible that this pattern may be repeated earlier in this patient's records – or perhaps in the records of other patients. 4. I invite you to consider the fitness to practice of [redacted], in view of the findings of this inquest. 5. I strongly urge the recipients of this report to listen to the recording of this inquest. This can be supplied electronically (via Cryptshare) or on a CD. The fact that a Regulation 28 report has been issued to the GMC should not be interpreted as a criticism of that organisation. This point has been made clearly in the case of *R (Dr Siddiqui and Dr Paeprer-Rochricht) v Assistant Coroner for East London*. I have raised my concerns using Regulation 28 of the Coroners Investigations Regulations 2013 in view of the serious nature of the concerns I have, and in view of the fact that previous NHS investigations have already taken place and not brought the telephone consultation point to light. I consider this a matter of concern for wider public safety. For the avoidance of doubt, whilst I would welcome replies from NHS England and the CQC to the issues I have raised, a formal response to this report is required only from the GMC.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe you / 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 9 January 2018. 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 : 1. Rose's family 2. [redacted] 3. CQC 4. LMC 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	**14.11.17** ***H.J.Connor***