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Atrumed Healthcare
C/o Luton Urgent GP Clinic
LU4 0DZ
UK
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Reference Number: ATR03
Date: 30th May 2022

Her Majesty's Assistant Coroner for Bedfordshire and Luton

Dr Sean Cummings

The Court House

Woburn Street

Ampthill

Bedfordshire

MK45 2HX

30 May 2022

Dear Sir

The inquest touching upon the death of Mandy Jane Dickerson

Thank you for your Report to Prevent Future Deaths issued pursuant to Regulation 28 Coroner (Investigations) Regulations 2013, dated 3 April 2022 and following the inquest touching the death of Mandy Jane Dickerson who sadly passed away on 30 April 2020.

I would like to take the opportunity on behalf of Atrumed Ltd to offer my sincere condolences to Mrs Dickerson's family and friends for their loss.

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Matters of Concern in respect of Atrumed Ltd

"1. In my view there was considerable reluctance on the part of Atrumed Ltd, led by CEO [redacted], to engage properly with my investigation. This resulted in the issue of a Schedule 5 Notice to [redacted], to attend a special court session, so that I did secure his attention and to impress on him the significance of a Coroner's investigation and that his cooperation was not optional, in large part to ensure future learning.

2. The computer system in use at the Urgent GP Care Centre was prone at the time (April 2020) to glitches which rendered the use of the "Sepsis template" to be "advised" rather than mandatory. Sometimes it would display and other times not. It is my view that had the Sepsis template been fully operational and mandatory then the signs of sepsis shown by Mandy Dickerson would have likely altered the clinical decision making and resulted in prompt treatment for sepsis with probable survival.

3. There was fundamental confusion with regard to the management of patients, out of hours, who the treating UGPC clinician felt should be assessed by a relevant speciality, in this case medical, and where the relevant speciality felt assessment was unnecessary. It was understood by Mr [redacted] and by the treating UGPC nurse that once the speciality registrar had made a decision then that decision was final and the only option was to discharge the patient, unless they were in extremis, when a 222 call could be made for emergency assistance from the nearby hospital. I was told that if the patient was returned to the ED, then the streaming nurse would simply refer them back.

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4. That view was flatly contradicted by Dr [redacted], Consultant in Emergency Medicine at the Luton and Dunstable University Hospital and Deputy Medical Director. He told me it was entirely open to the UGPC staff to refer to ED if there was difficulty. He did not accept that the ED would refuse to see patients referred back, saying it happened all the time.

5. There was in my view a failure to record and then to convey key information to the medical registrar who consequently may have given advice which was ill-informed. The nurse practitioner told me, in oral evidence and in a statement provided at the eleventh hour the night before the Inquest, that the measurements had been performed but simply not recorded. However, the remainder of the note was particularly and contemporaneously detailed with these critical observations being conspicuous by their absence. I found that the observations had not been made. In addition, no record was made of the name of the medical registrar making investigation of this element difficult."

Response

1. I am sorry that you formed the view that there was reluctance on the part of either Atrumed Ltd and / or myself to engage with your investigation. I can assure you that this was not the case. As you are aware, Atrumed Ltd is closely aligned with Luton and Dunstable Hospital (run by Bedfordshire Hospitals NHS Foundation Trust – "the Trust") in terms of the provision of the Urgent GP Care Centre. I have not previously been involved in inquest proceedings and I was initially under the impression that the Trust would co - ordinate with your office on both its own and our behalf . Immediately I became aware that you required assistance and information from Atrumed Ltd specifically, I provided it to you.

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2. The sepsis template and how it operates is part of the System One software. System One is a nationally used software and the function of its templates is outside the control of Atrumed Ltd. However, Atrumed Ltd has recently (1) changed the software module to an Urgent Care Module and (2) added a Sepsis Screening tool as a bolt on. This means that if a patient's observations are abnormal such that there is a risk of sepsis, this will be flagged up on the system. It is Atrumed's local policy (attached) that this tool is to be used by its clinical practitioners.

3. This paragraph addresses both paragraphs 3 and 4 of your concerns. Following the inquest and in conjunction with one another, Atrumed Ltd and the Trust reviewed the protocol that was in place for referrals between the hospital and the Urgent GP Care Centre and have revised it. The protocol now makes clear that the Urgent GP Care Centre can refer any patient back to the hospital for further assessment, whether or not it has the agreement of a speciality doctor. As a result, there is no longer any confusion between the Urgent GP Care Centre and the Trust in this regard. Protocol attached. The protocol has been shared with all clinicians and is available in all the consultation rooms and provided at induction.

4. As to paragraph 5 of your concerns, it is of course for each individual practitioner (in accordance with their relevant regulatory body and their professional obligations) to ensure that they record the key information about a patient and the patient's presentation and that they accurately report the same to any other practitioner that they may contact in respect of a patient. It is now, however, part of Atrumed's policy that practitioners must record (in a patient's records) the name and times of any specialty clinicians that they speak to (please see attached) We carry out monthly audits of the records to ensure that this is happening and any issues that are identified are discussed with the Trust out our joint clinical governance meetings.

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I hope that the above information provides you with the reassurance that action has been taken by Atrumed Ltd in respect of the concerns that you raised during the course of the inquest and in your Regulation 28 report.

Atrumed Ltd is committed to ensuring the high-quality provision of urgent GP care services and we will ensure that the lessons learnt as a result of this inquest continue to be implemented and monitored across our service.

Yours sincerely,

[redacted]

[redacted]
Chief Executive Officer

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