Dear HM Area Coroner Stewart OBE

I am writing this letter in response to the Regulation 28 letter: Report to prevent Future Deaths issued by the Coroner on 18 June 2025, following the inquest into the death of Mr Terence Colby.

The inquest took place on the 24th of September 2024, the medical cause of death was confirmed as 1a Peripheral vascular disease.

I first became aware of the Regulation 28 letter on 4 August 2025 when I received an email from the Practice Manager of Alexandra and Crestview Surgery on the 4th of August 2025.

I worked as a locum at Alexandra and Crestview Surgery when I saw Mr Colby on the 17th of August 2023. I last worked at this Surgery on 1st October 2024.

I understand that an expert in General Practice, commissioned by the court, raised concerns about my consultation with Mr Colby on the 17th of August 2023 at Alexandra and Crestview Surgery.

I have reflected on my consultation with Mr Colby that I had on the morning of 17th August 2023 and also extensively reviewed the notes from May 2023 (when he first started coming in to the surgery regarding his left foot) till September 2023. I first did this in July-August 2024, when I became aware of the expert's report. I currently do not work for the surgery and do not have access to the notes.

Below is the factual account of concerns raised from the consultation I had and the events thereafter,

I had seen Mr Terence Colby, an 82-year-old man with his wife, on the 17thAugust 2023 for the first time, who had come to see me as per 111 whom he had contacted the previous night. The appointment ledger notes (triage notes) for me said 'UTI- spoke to 111 last night, advised to get checked'.
I assessed Mr Colby for urinary symptoms, took a history, checked his urine and gave advice regarding symptoms not getting better.

I also noted that he had gout in the left foot and currently had developed an ulcer on the toe, which was being dressed, and that he was put on antibiotics and painkillers (started in the last 2-3 days). Mr Colby was a non-diabetic, nonsmoker with no previous history of ischemic heart disease or intermittent claudication.

Mr Colby mentioned some pain in the left ankle and lower leg, I checked his calf, for any signs of DVT/ cellulitis, which he had in the past.

When the pain in his toe started to get worse a day after seeing me, he was seen by a colleague who assessed and discussed with the vascular team. The vascular team did not think he had any risk factors for an urgent assessment and agreed to see him the following week.

However Mr Colby went to AE, the same night as the pain got worse. He was seen by the vascular team sooner; they diagnosed him as acute on chronic arterial insufficiency. They tried conservative ways to saving his leg, but as it failed, he went on to have below knee amputation.
He was doing well but unfortunately, he developed sepsis and was in intensive care. He gradually deteriorated over the next week and about 4 weeks after his amputation he sadly passed away.

The family questioned if the GP surgery had delayed the diagnosis of Peripheral vascular disease and hence an inquest was planned.

I was informed of the Inquest only in July 2024, although Mr Colby had passed away in September 2023. This was mainly after a report by an expert GP, that they were critical of one consultation the patient had with me.

There was a pre-inquest hearing in August 2024, I came to know that the Inquest would be a documentary one on the 24th of September 2024, and no-one will have to attend it.

I extensively reviewed the notes of Mr Colby in July-Aug 2024 to help me understand the events and reflect on my practice. I discussed the case with my appraiser in Dec 2024.

Mr Colby, who was 82 years old, non-diabetic, nonsmoker, no previous history of coronary artery disease or intermittent claudication, was seen 7 times between 22/5/23 and 8/8/23 by nurse practitioners, with a diagnosis of gout in the left 3rd and 4th toe. During this same time he was seen additionally by another nurse for CKD review and a GP for a fall/ left knee pain who focussed their consultation on what the patient had come in to see them for.

On 13/8/23- he contacted NHS 111- who referred him to A and E-James Paget Hospital.
111 notes say, presenting complaint: gout 4th toe left foot, travelling up the leg, change of colour, going to black.
Gout to 4th toe for months, travelling up the leg, changed colour- going black, in extreme pain. Toe looks ulcerated, h/o ulcers.
Adv: Ambulance- declined, family will take to ED.

There was a letter from AE saying Mr Colby did not attend A and E.
However, there is a letter saying that Mr Colby was assessed by the GP front door at James Paget Hospital A and E, and the notes say, wound left 4th toe, no injury. On treatment for gout. Lower leg foot very discoloured/ poor circulation.

14/8/23: urate blood test result: 0.39. (Patient was on allopurinol).
14/8/23 at 18:30: A picture of the toe ulcer that was sent by the patient, was seen by a senior GP at Alexandra and Crestview Surgery. The note in System One from GP says see photo, infected ulcer, script issued.
Mr Colby was started on antibiotics (flucloxacillin) and painkillers (co-codamol).

15/8/23, 15:04, Mr Colby was seen by a nurse and the wound was dressed.
Notes say left foot wound, cleaned and covered with soft pore (same as AE dressing), intermittent pain.
He was given a follow up for further dressing the following Monday the 21st august.

17/8/23: NHS111: leg painful, hard red swollen, frequently urinating, confused (being treated for gout, ulcer on toe, already on antibiotics)
User comments: urinary problems- dysuria, frequency, urgency. No pain, no haematuria, moments of confusion- wife said normal for him but concerned that it is happening more.
Left leg pain and swelling, pt has gout and an ulcer on leg. c/o worsening pain, leg not hot to touch, soft around calf, able to weight bear with difficulty.
User comment: leg has some discoloration, difficult to assess as they have said it darkens in the evening anyways.
This NHS 111 document says authored on 18/8/23 6:29
It also says encounter time 17/8/23 19:23 to 18/8/23 6:29
Document created 18/8/23 6:29
I am not sure given the timings on this document if this was even completed and scanned before I saw the patient on the morning of 17th august.

Mr Colby came to see me on the morning of 17th August 2023 and as the appointment ledger said 'UTI-

spoke to 111 last night, advised to get checked'.
I focussed my consultation on the urinary symptoms and checked his urine. I assessed him for what he came in for, like we generally do in general practice as we have 10 minutes a patient.
I reviewed his notes and made a note that he had gout in his left foot, currently being treated for an infected ulcer left foot and had a dressing applied. I have made a note of some pains in the left leg and foot- but no calf swelling (to rule out DVT – which he had in the past).

On reflection, of my consultation on the morning of 17th August 2023 with the benefit of hindsight,

At the time, I did not consider peripheral vascular disease or critical limb ischemia in this patient, the reasons could possibly be as follows,

1. There were no risk factors for peripheral vascular disease like diabetes, smoking, history of coronary artery disease. I don't remember seeing any mention of current or previous history of intermittent claudication.

2. On review, there is a possibility of information bias influencing my initial clinical assessment, since the triage notes on the appointment ledger said, 'possible UTI, advised to get checked as per 111' and the patients primary concern on the day also seemed to be UTI. This alignment may have reinforced a narrower initial focus on UTI, with less emphasis on concurrent symptoms.

3. Moreover, from the information as noted above of the timings on the documents from NHS 111, I am not sure if that letter from NHS 111 (about the contact in the early hours of morning 17/8/23), was scanned onto the patients notes, when he saw me on the morning of 17th August 2023. It seems likely that the patient, when he booked an appointment for the same morning at the surgery, verbally told the receptionist that it was about UTI, which she put on the ledger- triage notes for the doctor. (Often otherwise the receptionist put on something like, 'see letter from 111 NHS dated so and so').

4. Also, that a diagnosis of gout was already made by the nurse practitioner whom he had seen several times over the last 2-3 months. The nurse practitioner had last seen him on the 8th august 2023 and had noted that his symptoms were improved, but that he had a flare.

5. I would possibly have assumed that the nurse practitioner would have discussed with a GP colleague or sought advice and guidance from rheumatology regarding the diagnosis as he had seen the patient multiple times for the same reason. Often at the time of the actual consultation given the complexity of elderly patients, the time constraints (10 minute slots) especially if patients are with a family member (who also have information to give, ask questions), presenting with multiple problems, it can be very challenging to reconsider established diagnosis that has been ongoing for few months and noted as getting better.

6. I always go in early before my clinic starts and review the notes of all patients that are prebooked, this is mainly to read related background information, letters from hospital, other services and make rough notes of possibilities, new things to explore with the patient (which might not be on the patient's agenda) etc. However, this patient was booked on the same morning after I had already started my morning clinic. So perhaps I missed the opportunity of scanning the notes in a bit more depth.

7. The patient had been seen by multiple clinicians in the last 2-3 days regarding the new painful ulcer on the toe that he had developed (including a senior GP partner at the practice who had seen a picture of his toe ulcer and also the patient being seen face to face by a clinician at the

GP front door services at James Paget Hospital specifically for the ulcer and pain) and he had been issued antibiotics and painkillers.

8. The patient, when he came to see me mentioned 'some' pains in his lower leg and ankle, after discussing about the urinary symptoms which seemed to be his main concern. He did not mention any worsening pains in his toe or any colour changes to me. Very often if some symptom is bothering a patient or is very important to them, especially if it's not been sorted after seeing other clinicians, they often say that first and stress that it is important for them. If it's not mentioned, it can be very difficult to assess and explore fully regarding that symptom.

9. In most patients who have been put on antibiotics by a clinician, especially a senior doctor, we do wait for 48-72 hrs to assess the effect unless the patient mentions worsening of symptoms or new symptoms of concern.

10. Review of cellulitis history in the past:
    Mr Colby had a history of recurrent cellulitis – going back to 2006, often he had multiple attendances till things settled. In 2015- he was reviewed by the dermatologist- and a letter in October 2015 from dermatology says diagnosis- bilateral leg oedema with left leg dermatosclerosis, recurrent cellulitis with persistent athletes' foot on both sides. When the patient mentioned that he was getting some pains in the left ankle and lower leg, I thought more of DVT and cellulitis, (given that he had history of this in the past) rather than peripheral vascular disease.

In hindsight, I should have taken a deeper history exploring the pain by asking some direct questions, considered a diagnosis of peripheral vascular disease and performed a simple vascular examination. I should have documented antibiotic usage and compliance. Exploring the pain might have helped me assess if I needed to remove the dressing to see the ulcer.

Following this unfortunate incident,

1. I have reviewed the NICE guidance and CKS NICE on peripheral vascular disease in 2024.
2. I have made a list of important points below to re-enforce my understanding and learning of Peripheral arterial disease.
3. I have discussed the case with my appraiser at my annual appraisal in December 2024.
4. I have written in my appraisal for December 2024 about the CPD, which I have done from National library of Medicine/ PubMed, on critical limb ischemia and the important points in examination of feet in peripheral vascular disease.
5. I have planned to do a further CPD from BMJ best practice on Peripheral arterial disease in the coming weeks and note this in my appraisal for December 2025.
6. Following receipt of the Coroners Regulation 28 letter I self-referred myself to the General Medical Council on 7th of August 2025.

I have learnt a lot from the reading of guidelines/ articles on PubMed regarding peripheral vascular disease.

The reflection of the case in hindsight, reviewing the sequence of events as to why it happened and what I could have done to prevent it happening again, has taught me a lot.

It has changed my practice especially in relation to symptoms in lower limbs and consideration of the possibility of a diagnosis of peripheral vascular disease.

All this has helped me embed the learning very deeply, I am also planning to do further CPD, by reading BMJ best practice.

I now consider Peripheral arterial disease/ critical limb ischemia as a differential diagnosis in all patients presenting with pain and ulcer in the lower legs and feet.

I have the following embedded in the back of my mind,

1. On reflection about information bias, made above, highlights the importance of maintaining an open differential regardless of the triage wording embedding routine practice of reviewing the patient holistically beyond the presenting complaint.
2. 'Pain in legs especially on leg elevation and easing on hanging them – Arterial insufficiency pain' even if there are no risk factors. Perform simple tests, like checking the colour of the feet, temperature of the feet, checking for peripheral pulses, doing the Buerger's test- pallor on elevation and rubor on hanging them.
3. Explore pain by asking direct questions to get a better understanding of the possible diagnosis.
4. If something is not fitting in, challenge the diagnosis, think of alternatives.

I have read the NICE guidance on peripheral vascular disease since this incident and have changed my current practice which is :

1. I assess people for presence of peripheral arterial disease (PAD) if they have symptoms suggestive of PAD or history of diabetes, non-healing wounds on legs/ feet or unexplained leg pain.
2. If I suspect PAD, I ask for presence and severity of possible symptoms of intermittent claudication and critical limb ischemia (CLI). Examine legs and feet for CLI for e.g.: leg ulceration, examine for femoral/ popliteal/ foot pulses and measure Ankle Brachial Pressure Index.
3. I offer all patients with suspected PAD, information, advise, support and treatment regarding secondary prevention of CV disease.
4. I offer supervised exercise programme to all people with intermittent claudication, when available - 2 hrs a week over 3-month period, encouraging people to exercise to the point of maximal pain.
5. I will assess for Critical limb ischemia: This is characterised by persistent and severe ischemic rest pain associated with poor tissue perfusion, tissue loss and ulceration. The preferred option is to improve tissue perfusion through endovascular or surgical treatment, therefore reducing pain. In some cases, such treatment is not possible, which can result in continued pain. There is a 50% mortality rate within a year of diagnosis. These patients tend to be older and have significant co-morbidities which need to be optimised.

Pain in CLI is typically worse at night in bed because the limb is elevated, and perfusion does not have gravity to assist it. This results in sleep deprivation. It is common for these patients to attempt to sleep with legs hanging out of the bed or preferring to sleep in a chair. Ischemic pain is described by patients as relentless, unbearable and deep burning pain affecting all aspects of their lives. They are unlikely to pursue with normal activities and may need help with daily tasks. They often become irritable with strains placed on their relationships.

Patients with CLI require prompt referral to the specialist services for assessment for revascularisation. Delays in referrals/ treatment can result in poor outcomes including major amputation.

6. Offer paracetamol and either weak or strong opioids depending on the severity of the pain for patients with CLI.

As a GP professional I have always held high standard of care for my patients despite the current challenges. I regularly attend CPD events on weekday evenings and weekends on various topics in general practice to keep up with new information and guidance. As a GP, in the current scene, it is more and more noticeable that the consultations are getting ever so complex, with lack of resources, limited appointment time, extremely long waiting lists to see the specialists/ long queues at A and E, advancing age of the population with multiple co-morbidity and polypharmacy, driving higher demand for holistic person centred care that addresses complex physical, psychological and social care at primary care level.

I have been deeply saddened by this case. It has highlighted that there were so many learnings from the missed opportunities to address the root cause of concern through the patient's journey. I have learnt a lot from it, on reflection and reading various guidelines. I will continue to stay updated reinforcing my knowledge and learning.

Please let me know if you require any further information

Yours sincerely

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03/09/2025