	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS [redacted] **THIS REPORT IS BEING SENT TO:** 1. [redacted] **Chair &** [redacted] **Chief/Accountable Officer NHS Bromley Clinical Commissioning Group** 2. [redacted] **Chief Executive Bromley Healthcare / Beckenham Beacons UCC** 3. **The GP Partners, Cator Medical Centre** 4. [redacted] **Investigation Manager, Fitness to Practice Team, General Medical Council**
1	**CORONER** I am Andrew Harris, senior coroner for the jurisdiction of London Inner South
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 24.01.12 I opened an inquest into the death of **Jacqueline Allwood, case ref 126/12**, aged 47, dod 14th January 2012. The inquest was heard on 7th October 2013. The conclusion of the inquest was given by a narrative verdict: Mrs Allwood attended Cator Medical Centre where she saw a GP on Tuesday 3rd January 2012, limping with several days of calf pain. She received a brief examination and was given advice and a diagnosis of musculoskeletal pain. Failure to take an adequate history (which would have elicited a strong family history of thrombosis) and failure to refer to Accident and Emergency Department to exclude a possible Deep Vein Thrombosis (DVT) amounted to neglect. Death occurred at 01.25 on 14/1 at Lewisham Hospital, having collapsed at home with unsuccessful emergency resuscitation. Death was caused by pulmonary thromboembolism secondary to a DVT, which would have been preventable if she had been referred to hospital on 3rd January.
4	**CIRCUMSTANCES OF THE DEATH** 1. Circumstances related to presentation to the Urgent Care Centre The patient attended the Urgent Care Centre, Beckenham Beacons having awoken with calf pain three or four days previously. Her daughter says that she filled in a registration form and was then asked to go round to the general practice as she had not injured herself, where there was a service of direct access to patients of any practice, by agreement with the Urgent Care Centre. An urgent care centre registration form was inspected and other than demographic or contact details only requested information about "reason for visit today". The GP receptionist advised that there would be a two hour wait and entered the reason for visit under "Reported condition" as pain in right calf. The GP did not see the UCC registration form, advised that the information from it may or may not be entered on the computer system, and would be shredded. He gave evidence that he did not see the section in his practice's electronic record that requests

medications and past history, but it was blank in this instance, as it often was.

The A&E expert, [redacted] gave evidence that *patients presenting to an urgent care centre, walk in centre or out of hours are a much higher risk group than those who present to their own GP surgery. As a consequence*, his statement continued, *there must be clinically agreed protocols at the front end of any facility that receives undifferentiated patients that manage this higher risk population. Patients that present with certain high risk conditions such as chest pain, shortness of breath or calf pain must be directed to a facility that can exclude serious illness and this is usually the nearest Accident & Emergency Department.*

A witness from the UCC provided evidence of the UrgentCare Pathway and Reception Streaming Assessment form, which [redacted] does not remember her mother completing. It identifies several serious conditions or symptoms, but not including calf pain or DVT.

The GP, supported by the GP expert, [redacted] gave evidence that the risk of missing a diagnosis of possible DVT would be reduced, especially for busy GPs, if the patient could be asked to list past medical history, family history and medication, and to hand the form to the doctor at the start of the consultation.

2. Circumstances related to the consulting GP:

The GP was informed that the patient attended due to fear of having a DVT in view of family history. He considered DVT as a possible diagnosis but did not enquire further and so did not discover that four and possibly five members of the family had suffered from thromboembolism. The GP expert witness, [redacted] said that ascribing the pain to a history of getting decorations from the attic was insufficient to conclude as an alternative cause of pain when she reported no pain at the time. There was no record of the risk factors that were considered in this case other than no swelling. A daughter who accompanied the patient to the GP said that he concluded that there could not be a DVT as the calf would need to be severely swollen. Whilst the GP denied he said this, I accepted on the balance of probabilities the evidence of the daughter.

The GP expert said that the patient should have been referred to hospital solely on the basis of the history. He identified a third failure, which did not contribute to death, which was the failure to examine the patient adequately to assess the risk of DVT. The GP examined the legs whilst the patient was sitting with her shoes on and trousers rolled up. He only felt the painful calf and informed the court that visual inspection in this position was sufficient to determine whether there was difference of more than 3cm (a threshold for the Wells test) or whether there was ankle oedema.

The GP expert gave an opinion that this was an inadequate examination and that the patient should be lying on the couch with trousers off and both legs examined on both sides under a light. Expert advice of a GP confirmed that the threshold for referral was possible risk of DVT and that was met here and she should have been referred. Expert opinion evidence from an A&E consultant, Dr Metcalfe, confirmed that death would have been prevented if referred on 3rd as the patient would have been anticoagulated.

5 **CORONER'S CONCERNS**

During the course of the inquest the evidence revealed matters giving rise to concern.

1. Attendance at the Urgent care centre with or without referral to the adjacent general practice does not apparently have, as advised by an A&E expert, an agreed protocol for management of calf pain and suspected DVT. Evidence was heard that DVT is a relatively common condition, but missing the diagnosis is potentially catastrophic.

2. The GP expert gave evidence that there was an on going risk of future deaths of patients from undiagnosed DVT, in the light of the GP's training needs and said that the

	GP should review his practice. He advised that the coroner should consider referral to the GMC. The GP was asked if his examination of a patient with a suspected DVT would be any different now and he said no, apart from measurement of the calves. "to make sure that I'm not here again". Having heard the evidence of the GP expert, he said that he had had two discussions with his appraiser and there had been no actions which indicated that he needed further training. He also said that he had not made anyone lie on the couch in examinations since, but had referred more patients to hospital. To questioning he then agreed that taking shoes off was a good idea and that he would lie the patient on a couch in future. The GP expert said despite changes he had made, it would be reassuring to have further evidence about his practice and not just this situation. The **MATTERS OF CONCERN** are as follows. – (1) The registration, assessment and referral forms and consultation records of and between the Urgent Care Centre and Cator Medical Practice may not facilitate the early diagnosis of DVT and the need for a low threshold of referral to A&E. (2). Taking as a whole the evidence of the consulting GP, [redacted] it cannot be said that the public can be assured that he understands and accepts normative standards of practice with respect to history and examination and that he has made or will make changes in order to reduce risks of harm to patients.
6	**ACTION SHOULD BE TAKEN** (1) Bromley Clinical Commissioning Group, Bromley Health Care/ Beckenham Beacons Urgent Care Centre and Cator Medical Centre are asked to consider Matter of Concern (1) above and the recommendation of the expert GP about patients recording medication, PMH and FH in documentary form prior to seeing the doctor. (2) The General Medical Council are asked to regard this report as a referral to their fitness to practice team, consider Matter of Concern (2) and advise [redacted] whether a review of his practice or retraining is indicated.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 17th of December 2013. 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: [redacted] sister [redacted] daughter [redacted] GP I have also sent it to: [redacted] manager Bromley Healthcare Trust [redacted] expert Consultant in A&E [redacted] expert GP

	Prof Amanda Howe, Secretary of Royal College of General Practitioners Mr David Harrison, Public Health Policy and Strategy Unit, Department of Health, who may find it useful or of interest. 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. If you would like further information about the case, please contact my officer, Miss Lesley Brown, on 020 7525 0792, lesley.brown@southwark.gov.uk.
9	**[DATE]** 23rd October 2013 **[SIGNED BY CORONER]**

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **Re: Jacqueline Allwood Dod: 14th January 2010, Case number: 126/12** **Case Officer: Ms Lesley Brown, Tel no. 020 7 525 0792** **THIS REPORT IS BEING SENT TO:** **1. Dr Andrew Parson, Chair & Dr Angela Bhan Chief/Accountable Officer NHS Bromley Clinical Commissioning Group** **2. Mr Jonathan Lewis, Chief Executive Bromley Healthcare / Beckenham Beacons UCC** **3. The GP Partners, Cator Medical Centre** **4. Ms Amanda Brown, Investigation Manager, Fitness to Practice Team, General Medical Council**
1	**CORONER** I am Andrew Harris, senior coroner for the jurisdiction of London Inner South
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 24.01.12 I opened an inquest into the death of **Jacqueline Allwood, case ref 126/12**, aged 47, dod 14th January 2012. The inquest was heard on 7th October 2013. The conclusion of the inquest was given by a narrative verdict: Mrs Allwood attended Cator Medical Centre where she saw a GP on Tuesday 3rd January 2012, limping with several days of calf pain. She received a brief examination and was given advice and a diagnosis of musculoskeletal pain. Failure to take an adequate history (which would have elicited a strong family history of thrombosis) and failure to refer to Accident and Emergency Department to exclude a possible Deep Vein Thrombosis (DVT) amounted to neglect. Death occurred at 01.25 on 14/1 at Lewisham Hospital, having collapsed at home with unsuccessful emergency resuscitation. Death was caused by pulmonary thromboembolism secondary to a DVT, which would have been preventable if she had been referred to hospital on 3rd January.
4	**CIRCUMSTANCES OF THE DEATH** 1. Circumstances related to presentation to the Urgent Care Centre The patient attended the Urgent Care Centre, Beckenham Beacons having awoken with calf pain three or four days previously. Her daughter says that she filled in a registration form and was then asked to go round to the general practice as she had not injured herself, where there was a service of direct access to patients of any practice, by agreement with the Urgent Care Centre. An urgent care centre registration form was inspected and other than demographic or contact details only requested information about "reason for visit today". The GP receptionist advised that there would be a two hour wait and entered the reason for visit under "Reported condition" as pain in right calf. The GP did not see the UCC registration form, advised that the information from it may or may not be entered on the computer system, and would be shredded. He gave evidence that he did not see the section in his practice's electronic record that requests

	medications and past history, but it was blank in this instance, as it often was. The A&E expert, Dr Metcalfe, gave evidence that *patients presenting to an urgent care centre, walk in centre or out of hours are a much higher risk group than those who present to their own GP surgery. As a consequence*, his statement continued, *there must be clinically agreed protocols at the front end of any facility that receives undifferentiated patients that manage this higher risk population. Patients that present with certain high risk conditions such as chest pain, shortness of breath or calf pain must be directed to a facility that can exclude serious illness and this is usually the nearest Accident & Emergency Department.* A witness from the UCC provided evidence of the UrgentCare Pathway and Reception Streaming Assessment form, which Mrs Allwood does not remember her mother completing. It identifies several serious conditions or symptoms, but not including calf pain or DVT. The GP, supported by the GP expert, Dr Harborow gave evidence that the risk of missing a diagnosis of possible DVT would be reduced, especially for busy GPs, if the patient could be asked to list past medical history, family history and medication, and to hand the form to the doctor at the start of the consultation. 2. Circumstances related to the consulting GP: The GP was informed that the patient attended due to fear of having a DVT in view of family history. He considered DVT as a possible diagnosis but did not enquire further and so did not discover that four and possibly five members of the family had suffered from thromboembolism. The GP expert witness, Dr Harborow, said that ascribing the pain to a history of getting decorations from the attic was insufficient to conclude as an alternative cause of pain when she reported no pain at the time. There was no record of the risk factors that were considered in this case other than no swelling. A daughter who accompanied the patient to the GP said that he concluded that there could not be a DVT as the calf would need to be severely swollen. Whilst the GP denied he said this, I accepted on the balance of probabilities the evidence of the daughter. The GP expert said that the patient should have been referred to hospital solely on the basis of the history. He identified a third failure, which did not contribute to death, which was the failure to examine the patient adequately to assess the risk of DVT. The GP examined the legs whilst the patient was sitting with her shoes on and trousers rolled up. He only felt the painful calf and informed the court that visual inspection in this position was sufficient to determine whether there was difference of more than 3cm (a threshold for the Wells test) or whether there was ankle oedema. The GP expert gave an opinion that this was an inadequate examination and that the patient should be lying on the couch with trousers off and both legs examined on both sides under a light. Expert advice of a GP confirmed that the threshold for referral was possible risk of DVT and that was met here and she should have been referred. Expert opinion evidence from an A&E consultant, Dr Metcalfe, confirmed that death would have been prevented if referred on 3rd as the patient would have been anticoagulated.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. 1. Attendance at the Urgent care centre with or without referral to the adjacent general practice does not apparently have, as advised by an A&E expert, an agreed protocol for management of calf pain and suspected DVT. Evidence was heard that DVT is a relatively common condition, but missing the diagnosis is potentially catastrophic. 2. The GP expert gave evidence that there was an on going risk of future deaths of patients from undiagnosed DVT, in the light of the GP's training needs and said that the

	GP should review his practice. He advised that the coroner should consider referral to the GMC. The GP was asked if his examination of a patient with a suspected DVT would be any different now and he said no, apart from measurement of the calves. "to make sure that I'm not here again". Having heard the evidence of the GP expert, he said that he had had two discussions with his appraiser and there had been no actions which indicated that he needed further training. He also said that he had not made anyone lie on the couch in examinations since, but had referred more patients to hospital. To questioning he then agreed that taking shoes off was a good idea and that he would lie the patient on a couch in future. The GP expert said despite changes he had made, it would be reassuring to have further evidence about his practice and not just this situation. The **MATTERS OF CONCERN** are as follows. – (1) The registration, assessment and referral forms and consultation records of and between the Urgent Care Centre and Cator Medical Practice may not facilitate the early diagnosis of DVT and the need for a low threshold of referral to A&E. (2). Taking as a whole the evidence of the consulting GP, Dr Adlakha, it cannot be said that the public can be assured that he understands and accepts normative standards of practice with respect to history and examination and that he has made or will make changes in order to reduce risks of harm to patients.
6	**ACTION SHOULD BE TAKEN** (1) Bromley Clinical Commissioning Group, Bromley Health Care/ Beckenham Beacons Urgent Care Centre and Cator Medical Centre are asked to consider Matter of Concern (1) above and the recommendation of the expert GP about patients recording medication, PMH and FH in documentary form prior to seeing the doctor. (2) The General Medical Council are asked to regard this report as a referral to their fitness to practice team, consider Matter of Concern (2) and advise Dr Adlakha whether a review of his practice or retraining is indicated.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 17th of December 2013. 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: Mrs Beverley Carpenter, sister Ms Tanya Allwood, daughter Dr Saurabh Adlakha, GP I have also sent it to: Mrs Fiona Christie, manager Bromley Healthcare Trust Dr Stephen Metcalfe, expert Consultant in A&E Dr Patrick Harborow, expert GP

	Prof Amanda Howe, Secretary of Royal College of General Practitioners Mr David Harrison, Public Health Policy and Strategy Unit, Department of Health, who may find it useful or of interest. 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. If you would like further information about the case, please contact my officer, Miss Lesley Brown, on 020 7525 0792, lesley.brown@southwark.gov.uk.
9	**[DATE]** 23rd October 2013 **[SIGNED BY CORONER]**