NHS England

Your Ref: 1216/2

Private & Confidential

Dr Andrew Harris
Coroner for Inner South District
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Southwark Coroner's Court
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London Regional Team
Medical Directorate (South)
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[redacted]

31 March 2014

Dear Dr Harris

Re: Jacqueline Allwood (Deceased)

Firstly I would like to apologise for the delay in sending this to you.

This report is a response by NHS England to the concerns raised by the coroner following an inquest into the death of Jacqueline Allwood, case ref 126/12.

The inquest was held on the 7th October 2013.

NHS England apologises for the delay in the submission of the report and are grateful to the coroner for agreeing to extend the date by which this report is submitted.

The General Medical Council (GMC) have requested a copy of this report. For this reason a brief summary of the circumstances that gave cause for this inquest enquiry is given.

Circumstances of the concern raised:

Mrs Allwood was 47 years old when she died of a pulmonary thromboembolism secondary to a DVT on the 14th January 2012. Eleven days prior to her death, on the 3rd January 2012, Mrs Allwood had presented to the Urgent Care Centre (UCC) at Beckenham Beacon complaining of pain in right calf. She was triaged by the UCC reception staff to the adjacent Cator Medical Centre where she consulted Dr [redacted] a GP who was on the South London Medical Performers List at

the time. When [redacted] assessed Mrs Allwood he came to the conclusion that her symptoms were musculo-sketal in origin.

After investigating the circumstances pertaining to Mrs Allwoods death, the coroner delivered a narrative verdict which stated that the failure (of [redacted] 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 amounted to neglect.

The coroner wrote a report under paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

In this report the coroner identified two areas of concern that need to be addressed further:

- The processes between the Urgent Care Centre and Cator Medical Practice need to be reviewed to ensure they facilitate the early diagnosis of a DVT and the need for a low threshold of referral to A&*E.*

  NHS England have made contact with the Urgent Care Centre at Beckenham Beacon and Cator Medical Centre. It is understood that they have made representation to the coroner in separate correspondence. They inform NHS England that they have made amendments to the triage process and have introduced a new screening form to highlight medical and family histories.

- Assurance that [redacted] understands and accepts normative standards of practice with respect to the history and examination and that he has made or will make changes in order to reduce the risk of harm to patients

  This report will concentrate on this area of concern.

1. Sources of evidence reviewed by NHS England

NHS England has gathered evidence from various sources which will be described. As a result of this information gathering, the author has proposed an action plan which is intended to ensure that [redacted] has reviewed and changed his practice.

1.1. NHS England meeting with Dr Adlakha on 10th October 2013.

[redacted] sought this meeting with NHS England immediately following the Inquest on the 7th October 2013. This was thought to be indicative of how seriously Dr Adlakha had taken the severe criticism that he had received at the Inquest.

At the meeting [redacted] summarised his career and experience in much the same way as he had done at the Inquest hearing. He qualified as doctor in 2003 in India and passed the PLAB in the same year which allowed him to work in the UK. He undertook GP training which he completed in 2007 when he passed the MRCGP. He has a total of 12 months experience working in an A&E setting and 6 years as a GP. He declared that he has not had any previous serious complaints and in particular, to the best of his knowledge he has not previously misdiagnosed a patient presenting with a DVT.

[redacted] described his recall of the consultation with Mrs Allwood on the 3rd January 2012. The patient had presented to the Urgent Care Centre and had been assessed by a receptionist who had directed the patient to the adjacent Cator Medical Centre to be seen by a doctor. [redacted] said that he saw the patient promptly. The medical record suggested that it was a very short consultation (4 minutes) but he thought that reflected the time he took to write up the medical record rather than actually see the patient. Apparently the daughter who accompanied Mrs Allwood confirmed at the Inquest that it was an unhurried consultation.

[redacted] told NHS England that Mrs Allwood had presented with a 4 day history of pain in her right calf. He didn't recall noticing her limping. He obtained a history that she had undertaken an unusual activity for her in that she had been moving heavy Christmas decorations. As a result of this history, [redacted] developed a working diagnosis that her symptoms were of musculo-skeletal origin. He felt this hypothesis was supported by the fact that there was no obvious swelling of the leg when he examined her. [redacted] recalls giving Mrs Allwood advice on the conservative management of her symptoms.

[redacted] told NHS England how shocked he had been when he had learnt of Mrs Allwoods untimely death 11 days later.

He recognised this as a very significant event in his professional career. Not only had he been asked to write a report for the coroner but he had also been in receipt of a complaint from Mrs Allwoods daughter[1]. [redacted] had declared this complaint in his appraisal evidence for the appraisal years 2011 – 2012 and 2012 -13. At his last appraisal on the 7th March 2013 this complaint

[1] He wrote in his appraisal documentation that Mrs Allwoods daughter had filed a civil case against him.

was discussed and this appraisal documentation has been reviewed by NHS England. [redacted] wrote in his appraisal documentation:

'it has affected my confidence as far as diagnosis of DVT's is concerned. The deceased had very low risk for DVT but still developed one and died subsequently. I have to become more careful and vigilant about DVT's and try and refer to the Wells score when possible. Also I advise patients to monitor their symptoms closely and of course go to A&E.'

During the appraisal discussion the complaint was discussed. [redacted] said that he had discussed the presentation with a number of colleagues. However it was noted by NHS England that the knowledge gap that had been exposed had not been included in his PDP.

At the meeting with NHS England, it was established that prior to the Inquest, [redacted] had not fully understood his vulnerability to criticism and as a result he had not asked his defence organisation to accompany him to the Inquest[2]. [redacted] had also not expected the adverse media exposure, nor had he considered the possibility of referral to the GMC which could ultimately put his licence to practice at risk.

[redacted] attitude was respectful of the court process. He presented to NHS England as a doctor who had been humbled by his very difficult experience in the coroner's court and who was keen to learn from his mistake and perform to a higher standard in the future. He expressed a willingness to engage in whatever remediation process was suggested.

1.2. Regulation 28 Report

This report was dated the 23rd October2013 and NHS England has carefully read this report, its conclusions and recommendations.

1.3. Court transcript

NHS England obtained a copy of the recorded court proceedings. The intention was to listen to the evidence given by [redacted] as well as the evidence given by the expert witnesses to ensure NHS England fully understood the circumstances of Mrs Allwoods death and how the coroner reached his conclusions. This would help NHS England develop an appropriate action plan to ensure [redacted] understands and accepts the expected standards of practice.

The author noted that at the inquest it was assumed that the DVT which caused Mrs Allwoods untimely death must have been present at the time when she presented to the Urgent Care Centre 11 days earlier. Mrs Allwood

[2] NHS England understands that he had contacted the MDDUS when he was first notified by the coroner of the death of Mrs Allwood. He had sent his report to the MDDUS who had approved it.

did not attend her own GP or present again to the Urgent Care Centre during the intervening 11 days.

The coroner had called two expert witnesses. [redacted] who was an expert consultant in A&E. [redacted] presented evidence of the need for clinically agreed protocols in the Urgent Care setting, as he observed that patients who present to an urgent care facility are generally a higher risk group.

The second expert witness was [redacted] who was called as an expert GP. The coroner declared that the expert GP was personally known to him, having been colleagues in General Practice some years ago. The coroner declared that there was no conflict of interest as nowadays they see each other infrequently. At the time of the inquest, [redacted] was working in the Urgent Care Centre attached to St Thomas's Hospital. [redacted] was asked to comment specifically on [redacted] history taking, the examination undertaken, the management plan and the safety netting.

1.4. A copy of the medical record

NHS England obtained a copy of the medical record written on the 3rd January when Mrs Allwood presented at the Urgent Care Centre.

A transcript is recorded here for completeness sake.

Reported condition:
Symptoms: pain in right calf[3]
Consultation details:
History:
Dull, aching pain in the rt calf since 4/7. No recent trauma or sob. No swelling in the leg.
Examination:
Right calf appears normal. Minimal tenderness in the rt calf.
Diagnosis:
Musculoskeletal pain
Treatment:
Reassured, rest and ice the area and use ibuprofen prn and see. Review with gp prn.

[3] This would have been recorded by the receptionist when the patient first presented to the service

2. Assessment of the medical performance of [redacted] from which the Action Plan is drawn.

[redacted] acknowledged that this case had changed his practice and that he was now much more cautious when presented with a patient complaining of calf pain. However he has yet to present strong evidence of the change in his professional practice that occurred following this case.

The case raises issues that NHS England would expect to see evidence that [redacted] has either researched or reflected further upon, and considered more fully on how he might change his practice.

2.1 NHS England considers that [redacted] medical record keeping fell below the standard expected. He did not record the mechanism of injury/stress that he had obtained from the history he took and from which he surmised that Mrs Allwoods presentation was related to a musculo-skeletal problem. [redacted] also failed to safety net adequately. NHS England will expect [redacted] to attend a course on medical record keeping by no later than 30th June 2014. Following this, [redacted] will be requested to undertake an audit of his consultations against the criteria set by the IMAP[4] process and submit the outcome to NHS England by no later than 28th July 2014 of the course.

2.2. NHS England expect [redacted] to demonstrate that he has considered the comments from the expert witness who felt that a mark of good practice would be to have calculated the Wells score[5]. [redacted] observes that following this case, he is now more likely to calculate the Wells score. In this particular case, Mrs Allwood would probably have scored less than 2 which would suggest to the doctor that a DVT was 'unlikely'. NHS England expects [redacted] to reflect on the validity of the Wells score and how he plans to incorporate it into his day to day practice.

2.3. [redacted] did not record a family history in his medical record and does not recall actively seeking the history. Mrs Allwood's daughter recalls telling [redacted] that they had a family history of DVT's[6]. The coroner placed great importance on this history and felt that it probably outweighed all other evidence. NHS England would like to see evidence that [redacted] has given

[4] iMAP – interim Membership by Assessement of Performance (RCGP)

[5] The Wells score is thought to be a useful score to assess the probability of a patient having a DVT or not.

6 It is noted that the family history was not recorded in the GP held medical record. The court transcript does not record when the family came to realise that there was such a strong familial pattern, although there is an assumption this was known before Mrs Allwoods death.

greater consideration to this view and researched the genetic influence on the risk of venous thromboembolic disease.

2.4. [redacted] was criticised for his incomplete examination of Mrs Allwoods leg. [redacted] was surprised that the expert GP witness stated that all patients with a painful calf should remove their lower clothing (except for underwear) and be examined in the prone and supine position on the examination couch. [redacted] did not feel this was common GP practice and wasn't sure that all patients would accept this exposure in a GP surgery situation. However he accepted that he should have removed Mrs Allwoods shoes and socks so he had full exposure of Mrs Allwoods lower leg. He also accepts that he should have measured the calf diameter, if for no other reason than to be helpful should the patient present for a second time and this first measurement could be used as a comparator[7]. NHS England would like to see evidence that [redacted] has sought advice from other GP's as to how they examine the leg in a similar situation and has come to a considered opinion as to how he will go about such an examination in the future.

2.5. The GP expert witness alluded to the daily challenge of General Practice whereby the GP has to constantly weigh the balance of probability in the cases they see. GP's can find themselves criticised for unnecessary referrals especially when they are being overly cautious and yet when they get it wrong, the criticism and censure is severe. This aspect of general practice was not explored at any length at the Inquest but NHS England believe it is important for [redacted] to give great consideration to his future ability to weigh evidence especially when a similar case presents to him in the future. For this reason, NHS England expects [redacted] to read and research the body of academic articles that pertains to the diagnosis of venous thromboembolism and to summarise what will change his practice.

3. Proposed Action Plan

3.1 This case starkly illustrates how difficult the diagnosis of a DVT can be for General Practitioners but [redacted] needs to demonstrate that he has carefully considered all the factors that present in this case and to write reflectively:

7 At the time of post mortem the difference in leg circumference between the left and the right leg was less than 3 cm difference, measured at 10cm below the tibial tuberosity. If he had elicited and recorded this sign, it would not have supported the diagnosis of a DVT.

- on the research he has undertaken relating to the clinical diagnosis of DVT and the challenges it presents to the practitioner.
- on the significance of a family history of thromboembolic disease and the current hypothesis of a genetic association.
- about the medical history he actively seeks when presented with a patient complaining of a painful calf
- about the medical examination he will undertake in the future. What does he think is an appropriate method to examine the patient?
- how this case has changed his management of future patients with similar presentations and in particular how he would safety net (and record it) more effectively in future.

This reflective report should be submitted to NHS England by 14th May 2014.

3.2 [redacted] needs to improve his record keeping. It is expected that he will attend a course on medical record keeping by no later than 30 June 2014. After the course he is to write a reflective account of what he has learnt and how it will change his practice and share this with NHS England. To be completed by 28th July 2014.

3.3 After [redacted] attends the course on medical record keeping he is to undertake an audit of his medical record keeping. This will follow the method employed by the IMAP process. See Appendix. To be completed by 28th July 2014.

NHS England plan to meet up with [redacted] again in the next month so this action plan can be discussed in detail and the exact timetable agreed.

Yours sincerely

[redacted]

[redacted]

Associate Medical Director (South London Area Team)
MBBCh, FRCGP, LLM, PGCE, DRCOG, DGM

Appendix 1:

Taken from :

Interim Membership by Assessment of Performance (iMAP2)

April 2013

https://www.rcgp.org.uk/GP-training-and-exams/~/media/Files/GP-training-and-exams/iMAP/iMAP2%20Handbook%20Jul%2013.ashx

This proforma will be used as the basis of a self – reported and self – analysed medical records review. [redacted] will be expected to reflect on the outcome after the exercise has been completed.

[redacted] will be asked to look at 30 consecutive records.

13. Good medical records

EVIDENCE/PROFORMA
10 copies of single note entries. Tick if information is present in your records.

Record Number	1	2	3	4	5	6	7	8	9	10	Total	%
Surgery or visit consultations are dated												
Entry understood in entirety												
History recorded												
Examination recorded												
Investigations recorded (0 if not applicable)*												
Problem definition/Read code												
Management												
Significant negative findings (if and when appropriate)												