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OUR REF: **RA/396736-001**
YOUR REF:

16 August 2018

Ms Margaret Jones
Assistant Coroner for Stoke-on-Trent and North Staffordshire

By email only: coroners@stoke.gov.uk

Dear Ms Jones

Inquest touching upon the death of Dr John Robert Maltby Worthington
Response to Regulation 28 Report on behalf of [redacted]

I write in relation to the above matter, with which I am assisting Dr Verso.

I note that on conclusion of the inquest on 28th June 2018, you made a Regulation 28 Report to [redacted] and the Royal Stoke University Hospital. This is a response to that report on behalf of [redacted]

I understand that [redacted] attended the inquest as a witness of fact and not as an Interested Person. [redacted] not therefore legally represented at the inquest and I have not seen any of the disclosure relating to this inquest.

I note from the Regulation 28 Report that your concern relating to [redacted] relates to a failure to take and/or record a full set of observations.

While I do not wish to rehearse the detail of [redacted] consultation with Dr Worthington, I would like to point out that [redacted] has obviously reflected on this case a great deal and is of the view that there were many aspects of the care provided that were of an appropriate standard; which I have highlighted below.

Dr Worthington had contacted the Audlem Medical Practice ["the Practice"] on 13th April 2017 for a review of an ECG carried out by the paramedics the previous day. [redacted] wanted to assess Dr Worthington and review the ECG in person and asked him to attend the Practice for an urgent appointment that morning.

When [redacted] saw Dr Worthington, she took a full history and documented that the pain in Dr Worthington's chest and back had worsened the previous evening though it had improved by the time he was seen in the Practice.

[redacted] examined Dr Worthington and found that he was not short of breath, his pulse was 92 and his heart sounds were normal. [redacted] listened to Dr Worthington's chest and noted that it was clear with good entry throughout. There was no bruising or swelling visible on Dr Worthington's back or chest and there was no midline bony lumbar spine tenderness. [redacted] noted that Dr Worthington was tender just lateral to L1 and L2 on both sides, and over his lower ribs posteriorly and anteriorly.

[redacted] reviewed the ECG changes and suggested to Dr Worthington that the ECG was repeated in hospital at a routine outpatient appointment. [redacted] recorded that Dr Worthington did not think this was necessary and preferred to take analgesia as required and self-monitor for any change or worsening of symptoms.

[redacted] felt that she provided a high standard of care to Dr Worthington at this consultation; having insisted that he attended the Practice for a face to face consultation and the carrying out a detailed assessment. [redacted] clinical opinion at the time was that there were no untoward signs of head injury and there were no clinical signs at the time to suggest that any further investigations were needed. [redacted] had listened to Dr Worthington's chest and concluded that the lungs were clear.

With regards to the criticism of failing to take and/or record a full set of observations, [redacted] agrees that she has not recorded Dr Worthington's blood pressure or O2 saturations. [redacted] cannot recall now whether she undertook these observations. [redacted] will be more aware of documenting a full set of observations in future.

When [redacted] examined Dr Worthington she did not feel that an x-ray of the ribs/lumbar spine was indicated given that Dr Worthington was not suffering from any midline lumbar spine bony tenderness. In retrospect however, [redacted] accepts that an x-ray may well have picked up the fractures sustained by Dr Worthington which in turn may have led to a different outcome. Having reflected on this aspect of the case, [redacted] is now more likely to send patients of a similar age for x-rays in future after any significant trauma.

In conclusion therefore the learning points that [redacted] has taken from this incident are as follows:

- Always take and document a full set of observations when examining patients in future; and
- Consider referrals for x-rays in older patients when they have suffered a significant trauma.

[redacted] is completing an online course in record keeping and has also taken this opportunity to review the GMC's guidance on record keeping.

In addition, [redacted] also now appreciates the importance of providing a detailed report to the Coroner when requested and this point has also been discussed at a Practice-wide level.

Upon receipt of the Regulation 28 Report, I can confirm that [redacted] self-referred to the GMC. The GMC have considered the matter and sought medical advice and have closed their enquiry. I enclose a copy of [redacted] self-referral and the GMC's response.

I hope that the actions described above provide you with the assurance that this matter has been taken seriously by [redacted].

Please do not hesitate to contact me if [redacted] can be of any further assistance.

Yours sincerely

[redacted]
SOLICITOR

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