From: [redacted]
Sent: 25 January 2021 16:57
To: [redacted]
Subject: RE: Regulation 28 Report - Mr Peter James Michael UNSWORTH

Dear [redacted],

I am writing to confirm the action that the General Medical Council has taken in response to HM Assistant Coroner Caroline Topping's Regulation 28 report into the death of Mr Peter James Michael Unsworth.

Upon receipt of the report the GMC's Triage team has worked with our local Employer Liaison Service to obtain further information in relation to the incident and doctor's involved. This resulted in obtaining the local investigation report into the incident from Ashford and St Peter's Hospital.

We have now reviewed the local report and have taken the following actions in relation to the two doctors involved:

1. **Dr [redacted] – GMC Reference [redacted]**

We note that Dr [redacted] requested specialist advice from a Consultant Haematologist which was provided over the telephone. As a result of Dr [redacted] interpretation of the advice provided to him he reduced the patient's dose of clexane. The conversation with the Haematologist was not added to the clinical notes and a letter confirming the decision to reduce the dose was not sent for a month after the conversation happened.

Sadly after this reduction the patient went on to suffer pulmonary emboli which occluded his pulmonary arteries causing him to pass away on 29 July 2018.

After review the GMC's Triage team have decided that further enquiries are required into the allegations against Dr [redacted]. As a result a provisional enquiry has now been opened which will allow the GMC to obtain copies of Mr Unsworth's clinical records and an independent clinical opinion. The clinical opinion will address whether there are any fitness to practise concerns about the actions of Dr [redacted].

We will attempt to complete our initial review into the actions of Dr [redacted] in around three months. This may be impacted by the current pandemic but where possible we are progressing our investigations whilst at the same time being mindful of the local environment and challenges.

2. **Dr [redacted] – GMC Reference [redacted]**

In addition to the actions of Dr [redacted] the GMC's Triage team has also review Dr [redacted] involvement in the care provided. Our decision maker has decided that no further action or investigation should be carried out into Dr [redacted] actions.

In making their decision they made the following comments:

> "We have carefully considered all of the information you provided within your Regulation 28 notification. We have also sought further information from the Responsible Officer (RO) at St Peter's Hospital.
>
> We have reviewed a copy of the hospital's Significant Incident report which explains that it is unlikely that Dr [redacted] would have advised that a reduction in dose was appropriate, as it would not be her normal practice in this scenario as it would be contrary to established management principles.
>
> Furthermore, the information we received indicated that it would normally be for the recipient of the advice to record it in the medical notes, and where a doctor is giving advice over the phone, the person giving the advice would not always be expected to record it.
>
> Taking this information into consider, it appears that the responsibility of ensuring a written record was made, did not lie with Dr [redacted]. We can see that there has been a full SI investigation which has addressed these issues, as such we don't consider any further action is required by the GMC regarding Dr [redacted]."

I hope that this email has confirmed the actions and decisions taken in relation to the Regulation 28 report. If you would like to discuss this matter please do not hesitate to contact me on my direct telephone number.

Kind Regards,

[redacted]

Investigation Manager

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