EXPERT MEDICAL REPORT FOR THE COURT

ON BREACH OF DUTY

Prepared by:

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Date: 17/10/2016

Claimant: x

(**Date of Birth:**)

PREPARED AT THE REQUEST OF:

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1. BRIEF CURRICULUM VITAE

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2. SUMMARY OF INSTRUCTIONS AND ISSUES TO CONSIDER

2.1 On 27 February 2011, Dr W failed to refer Mr X to a specialist for an urgent appointment for further assessment in view of the occasional bright red rectal bleeding and a persistent altered bowel habit at the time of the consultation.

2.2 A failure on 31 March 2011, 16 May 2011, 25 May 2011, 9 August 2011, 22 August 2011, 15 March 2012, 20 November 2012, 24 January 2013 and 8 April 2013 to carry out a rectal examination in view of the continuing problems with altered bowel habits. It is alleged that had such an examination taken place rectal bleeding would have been apparent and an urgent referral to a specialist for further investigation would have been required.

2.3 To provide a comment on breach of duty in relation to each allegation and in respect of each consultation.

2.4 To report on the standard of care provided by all GPs.

Although I am instructed by X this report is prepared as an independent expert opinion for the Court and not for X. My full declaration is set out at the end of this report.

3. DOCUMENTATION, MATERIALS AND INFORMATION PROVIDED

3.1 Letter of claim dated 27 March 2015

3.2 Draft statement from Dr V

3.3 Draft statement from Dr B

3.4 GP medical records from.

3.5 GP medical records from .

3.6 Medical records from NHS Foundation Trust.

4. HISTORY AS GIVEN BY THE LETTER OF CLAIM

4.1 The history is taken from the Letter of Claim as the Claimant is deceased and the claim is brought by his personal representative.However for the purposes of this report I will refer to X as the Claimant.

4.2 The Letter states that the Claimant attended Group Practice on 22/2/ 2011 and was seen by the Defendant, Dr W,
He had pain for 5 years around the area of his appendectomy scar and this had worsened recently. He also complained of multiple other gastrointestinal symptoms such as bloating, nausea, heartburn, erratic bowels and rectal bleeding. The last episode of bleeding was 2 weeks prior to the appointment. There was no history of weight loss. It was noted he had been previously investigated with an ultrasound scan and endoscopy. Abdominal examination was carried out and investigations organised (blood tests, ECG urine dip). It was noted that a rectal examination would need to be performed when the Claimant was reviewed with the results.

4.3 Blood test results were entered in the notes on 1/3/2011. These showed a mild renal impairment and a positive helicobacter pylori test (helicobacter is a bacteria found in the stomach and associated with gastric ulceration). The Claimant was advised to contact his GP.

4.4 The Claimant was reviewed by the Defendant, Dr W on 31/3/2011. He had ongoing abdominal pain but no further rectal bleeding was noted. The ultrasound scan was scheduled for the following week. The helicobacter test was discussed and treatment commenced. Follow up was arranged for 1 month.

4.5 On 16/5/2011, the Claimant was seen by another Defendant, Dr V. He had been triaged with abdominal symptoms and one episode of vomiting. The consultation notes state the Claimant had ongoing right sided pain associated with indigestion. He had a tendency to constipation although his bowels had been normal for the past few days. He also complained of intermittent testicular tenderness. Examination revealed some tenderness in the left and right iliac fossa (lower abdomen), right epigastrium and hypochondrium (upper abdomen). Testicular examination was normal other than a mild tenderness to the cord on the left side. He was prescribed lansoprazole (a medication for acid reflux), mebeverine (used for irritable bowel and bloating symptoms) and ciprofloxacin (an antibiotic).

4.6 The Defendant Dr V reviewed the Claimant on 25/5/2011. He had ongoing right lower abdominal pain and pain in the left testicle. There was no associated bowel symptoms and the plan was to review following the ultrasound examination.

4.7 The results of the ultrasound scan were received on 22/6/2011.

4.8 The Claimant was seen on 9/8/2011 by the Defendant, Dr J. He had ongoing right sided abdominal pain. His bowels had been loose for a few days and black on one occasion. The ultrasound scan was noted to be normal. The Claimant had ongoing dyspeptic symptoms despite treatment. Examination revealed some tenderness in the right lower abdomen only. Blood tests were organised and the Claimant was referred for an upper gastrointestinal endoscopy on 12/9/2011.

4.9 On 11/9/2011, the Claimant saw the Defendant, Dr B complaining of abdominal cramps. He had associated bloating and had to open his bowels to get relief. He denied rectal bleeding and was noted to have lost 0.5 stone in 3 days. The Claimant was told he had irritable bowel syndrome with possible postoperative adhesions and commenced on mebeverine (antispasmodic medication).

4.10 The Claimant presented with back pain on 1/10/2012 and denied bladder and bowel symptoms.

4.11 The Claimant was reviewed by the Defendant, Dr H on 20/111/2012. He had ongoing abdominal bloating but no bowel or bladder symptoms. He stated he had colonic irrigation 2 weeks previously and was told he had a narrowing on the right hand side. He told the Defendant he had forgotten to attend the colonoscopy appointments but now would do so. Abdominal examination was noted to be normal and he was referred again for colonoscopy and blood tests.

4.12 On 24/1/2013 the Claimant was seen by the Defendant Dr S .He complained of feeling unwell for 5 days with a headache, generalised pains and urinary frequency. Urinalysis showed evidence of an infection and he was treated with antibiotics.

4.13 The Claimant was seen on 8/4/2013, complaining of a sensation of passing glass when bowel opened. Digital rectal examination showed some redness and he was diagnosed with an anal fissure.

4.14 The Claimant then changed GP practice. He was seen on 30/4/ 2013 with rectal bleeding and chronic abdominal pain. At this point he was referred under the 2 week rule to the colorectal surgeons. He was diagnosed with a rectal carcinoma on 16/5/ 2013.

5. SUMMARY OF RELEVANT MEDICAL RECORDS

5.1 The Claimant was seen on 22/2/2011 by the Defendant Dr W. The history notes 5 years of pain around appendectomy scar (right side, lower abdomen), which had worsened recently. This was associated with bloating, nausea, heartburn and erratic bowel motions. He had occasional bright red bleeding per rectum, the last episode 2 weeks previously. Abdominal examination revealed right sided tenderness. Further investigation was arranged which included blood tests, abdominal ultrasound scan and ECG. A note was made that “discussed will need pr [digital rectal examination] next time”.

5.2 The results of the blood tests are recorded in the notes on 1/3/2011. These show mild renal impairment and a positive helicobacter pylori test. This is a test for a bacteria in the stomach which is associated with gastric ulceration.

5.3 The Defendant Dr W reviewed the Claimant on 31/3/2011 where the results were discussed. He was prescribed the eradication treatment for helicobacter pylori (an acid suppressant tablet and two antibiotics). An abdominal ultrasound was due the following week. The Claimant was noted to have ongoing abdominal symptoms but no further rectal bleeding.

5.4 On 16/5/2011, the Claimant was reviewed by the Defendant Dr V. He had ongoing right sided abdominal pain associated with indigestion. He had vomited once that day. He was noted to have a tendency to constipation but had opened his bowels normally for the last few days. He was also noted to have intermittent testicular discomfort. On examination he was found to be tender in his abdomen and mildly tender on palpation spermatic cord (attached to the testicle) on the left side. It was noted he was waiting for an abdominal ultrasound and recent blood tests were normal including liver function tests. The Defendant prescribed a different antacid medication (lansoprazole), an antispasmodic medication (mebeverine) and another antibiotic (ciprofloxacin), with a plan to review in one week.

5.5 The Defendant Dr V reviewed the Claimant on 25/5/2011. It was noted he had ongoing right lower abdominal pain with no associated diarrhoea, constipation or vomiting. Ongoing pain in the testicle was noted. As he had tenderness in his testicles a testicular ultrasound scan was organised.

5.6 The Claimant was seen again on 9/8/2011 by a different GP, the Defendant Dr J. He noted persisting abdominal pain mostly in the right lower abdomen, which had been present since his appendectomy. This was associated with a few days history of loose bowels, which had been black on one occasion. The Claimant had ongoing dyspeptic symptoms. It was noted that the previous abdominal ultrasound was normal. Abdominal

examination revealed tenderness in the right lower abdomen. The Claimant was referred for an upper GI endoscopy (camera test of the upper gastrointestinal tract-oesophagus and stomach) as well as repeat blood tests. It was thought that the pain was related to adhesions and may need further assessment.

5.7 The Defendant Dr B saw the Claimant on 22/8/11.The Claimant was noted to have abdominal cramps associated with bloating, relieved by having his bowels open. He has lost 0.5 stone in three days but had a good appetite. He was noted to suffer from heartburn and avoided certain trigger food. It was noted that the Claimant “denies PR bleed”. Abdominal examination was unremarkable other than slight tenderness in his upper abdomen. The differential diagnoses of irritable bowel syndrome or post-operative adhesions were considered. He was prescribed mebeverine (an antispasmodic). It was noted that he had been referred for an endoscopy.

5.8 The Claimant was next seen again for this problem on 15/3/2012 by the Defendant Dr B. He presented with abdominal cramps associated with a sensation of bloating. It was noted that he felt that “his abdo is going to burst”. He had no change in his bowel habit and mebeverine helped with the cramps. He had lost half a stone over the preceding 6 months. He had forced himself to vomit 2 days prior to this and noted a few specks of blood. It was noted that he had “no melena” [description of stool due to bleeding in the upper gastrointestinal tract]. The Claimant had never received the letter for endoscopy booked for August 2011 so was referred again.

5.9 On 1/10/2012 the Claimant presented with back pain and it was noted that he had no associated red flag symptoms (such as weight loss) and that he denied bowel or bladder symptoms.

5.10 The Claimant saw another GP, the Defendant Dr H on 20/11/2012 with ongoing abdominal bloating. He was noted to have no bowel changes, no weight loss or “other symptoms”. The Claimant had undergone colonic irrigation 2 weeks previously and was told he had a narrowing on the right side. It was stated that he had previously failed to attend for colonoscopy. Abdominal examination was normal. He was referred for a colonoscopy routinely as the Defendant did not feel he met the fast track criteria. Routine blood tests were organised.

5.11 There is a letter in the records from the colorectal clinic on 9/1/2013. It states that the Claimant was not aware of why he had been referred and that he had no symptoms. It states that the Claimant had previously had abdominal pain but had no pain since July or August and had no bowel symptoms. The surgeon felt there was no reason to investigate the Claimant but that if the pain recurred he should be re-referred and a CT scan would be organised.

5.12 The Defendant Dr S saw the Claimant on 24/1/2013 when he presented with feeling unwell for 5 days, with headaches and urinary frequency. He had had an episode of diarrhoea 3 days ago. He was found to have a low grade temperature and

urinalysis was suggestive of a urinary tract infection. He was prescribed antibiotics. The result of the urine culture was recorded the following day as no growth.

5.13 On 8/4/2013 the Claimant consulted the Defendant Dr B. He was noted to have a history of “passing glass on opening bowels”. It was noted that he had no bleeding, change in bowel habit, weight loss or constipation. On digital rectal examination he was found to have “some redness around 7 o’clock position”. He was diagnosed with an anal fissure and prescribed topical steroid and local anaesthetic cream.

5.14 The Claimant then changed GP practice to Medical Centre and was seen on 30/4/2013 by Dr Y. The Claimant was noted to have rectal bleeding on 3 occasions in the last 8 weeks and tenesmus (sensation of needing to open bowels). The notes state “stools softer, some red blood, last night urge to go and red blood PR” He was examined and it was noted “PR OK”. It was noted that he had previously been referred for a CT scan but it was declined. A fast track referral to the colorectal surgeons was done. The Claimant was seen in the clinic on 15/5/2013 and diagnosed with a rectal carcinoma.

6. SUMMARY OF RELEVANT WITNESS STATEMENTS

6.1 I have sight of the witness statements for Dr B and Dr V only.

6.2 The Defendant Dr V saw the Claimant on two occasions, on 16/5/2011 and 25/5/2011. The Defendant states that the Claimant had a history of right sided abdominal pain associated with indigestion and one episode of vomiting. Examination revealed right sided upper abdominal tenderness and bilateral lower abdominal tenderness. The Defendant felt that in light of a history of pain around the appendectomy scar, absence of altered bowel habit or bleeding and examination findings that he was possibly suffering from post-operative adhesions. As a result mebeverine was prescribed as well as an alternative antacid. The Claimant was also noted to have testicular pain and cord tenderness and prescribed ciprofloxacin. When the Claimant was reviewed a week later with ongoing symptoms, the working diagnosis was still thought to be adhesions but a testicular ultrasound was organised as well.

6.3 The Defendant Dr B saw the Claimant on the 22/8/2011, 15/3/2012 and 8/4/2013. Dr B was a GP registrar at the practice on these dates and I note that the Defendant has a surgical background having obtained Membership of the College of Surgeons with a Diploma in Laparoscopic Surgery.

6.4 Dr B states that the Claimant presented with bloating and abdominal cramps relieved by opening his bowels. He also had a history of heartburn and had a 3 day history of weight loss. The Defendant states that the Claimant denied any symptoms that would suggest a cancer. On examining the Claimant he noted upper abdominal tenderness only and did not feel that a rectal examination was indicated. A presumed diagnosis of irritable bowel syndrome or adhesions was made based on the history, examination and previous history of helicobacter pylori.

6.5 Dr B next saw the Claimant on 15/3/2012 when he presented with ongoing symptoms. He states that he had lost weight over the previous 6 months but specifically had no change in bowel habit or melena (as he had been taking an anti-inflammatory tablet which can cause stomach bleeding. The Defendant states that as the Claimants symptoms pointed towards an upper GI pathology rather than a lower pathology a rectal examination was not performed. It was decided to refer the Claimant for an upper gastrointestinal endoscopy examination.

6.6 On 8/4/2013 Dr B states that the Claimant was seen with symptoms of a painful rectum and on examining him he was found to have redness which was thought to be consistent with an anal fissure. A full rectal examination was not performed as it was deemed to have been too painful.

7. OPINION ON BREACH OF DUTY

7.1 I have been asked to comment on breach of duty in relation to each of the allegations (2.1, 2.2) and in respect of each consultation. I will take each Defendant in turn.

7.2 It is recommended that all patients over the age of 40 who present with rectal bleeding either of new onset, persistent or recurrent should be referred for further investigation (ref 10.1). It is clear from the medical record that when the Claimant presented on 22/2/2011 to the Defendant Dr W, he had symptoms of rectal bleeding (without any anal symptoms suggestive of haemorrhoids) and erratic bowel habit. In a patient of this age (41 years) who was also complaining of pain and tiredness a reasonably competent GP should consider the differential diagnosis of colorectal cancer and inflammatory bowel disease and refer for further investigation. The request for an abdominal ultrasound investigation was not an appropriate investigation of the Claimant's symptoms which suggested underlying bowel disease.
Dr W has also written "will need pr next time" but this did not occur nor any reason given as to why a rectal examination was not performed when the Claimant was reviewed on 31/3/2011.
Therefore it is my opinion that there is a breach of duty on the part of Dr W in failing to refer the Claimant at the time of presentation on 27/2/2011 and failure to perform a rectal examination when reviewed on 31/3/2011.

7.3 The Defendant, Dr V saw the Claimant on 16/5/2011 and 25/5/2011.From the records it appears that the Claimant mainly had upper gastrointestinal symptoms, on a background of positive Helicobacter Pylori blood test and longstanding dyspepsia (he had an upper GI endoscopy in 2008). He also complained of testicular pain.
It is my opinion that on these occasions a reasonable body of GPs would not perform a rectal examination and therefore the Defendant is not in breach of duty of care.

7.4 The Defendant Dr J saw the Claimant on 9/8/2011 when he had persistent abdominal pain with a history of loose bowels, black on one occasion. The Claimant is referred for an upper gastrointestinal endoscopy, but given the long standing history of lower abdominal pain, and current change in bowel habit, it is my opinion that he should have been referred for a colonoscopy (lower bowel investigation).
I am of the opinion that given the history of black motions and abdominal pain the Claimant should have had a rectal examination and therefore the Dr J is in breach of duty of care.

7.5 The Defendant Dr B saw the Claimant on 3 occasions, 22/8/2011, 15/3/2011 and 8/4/2013.During the first 2 consultations, the Claimant had symptoms of abdominal cramps, bloating and weight loss and a presumed diagnosis of irritable bowel syndrome was made. The Defendant argues that he did not perform a rectal examination as his

symptoms were suggestive of upper gastrointestinal pathology and therefore referred him urgently for an upper GI endoscopy. However I am of the opinion that given these symptoms, particularly those of pain and weight loss a similarly competent GP would have performed a rectal examination. I note that Dr B was a GP registrar at the time and has completed his surgical training. I therefore am of the opinion that there is a breach in duty of care in failing to perform a rectal examination on the first 2 occasions. With respect to the consultation on 15/3/2011, I conclude that a reasonable body of GPs would not have performed a rectal examination in someone presenting with an anal fissure if the history and examination findings were suggestive of such a diagnosis. I am therefore of the opinion that Dr B is not in breach of duty on this occasion.

7.6 The Defendant Dr H saw the Claimant on 20/11/2012. The Claimant was referred for a colonoscopy as a routine appointment with symptoms of abdominal bloating and a history of right sided narrowing on a colonic irrigation procedure 2 weeks previously. Dr H states that the Claimant did not meet the criteria for a fast track (suspected cancer) referral but she had failed to perform a rectal examination so a rectal mass had not been excluded. It is my opinion that failure to perform a rectal examination at this point amounts to a breach of duty of care.

7.7 The Defendant Dr S saw the Claimant on 24/1/2013 with symptoms of fever and urinary frequency. Urinalysis was consistent with a urinary tract infection and I am of the opinion that there was no failure to perform a rectal examination and hence no breach of duty of care.

8. SUMMARY OF CONCLUSIONS

8.1 With respect to the allegation that on 27/2/2011 Dr failed to refer Mr Xl to a specialist for an urgent appointment for further assessment in view of the occasional bright red rectal bleeding and a persistent altered bowel habits I conclude that there is a breach of duty of care

8.2 I am of the opinion that there was a breach of duty of care to perform a rectal examination on the occasions of 31/3/2011 (Dr W), 9/8/2011 (Dr J), 22/8/2011, 15/3/2011 (Dr B), and 20/11/2012 (Dr H). On each of these occasions I am of the opinion that the Claimant had symptoms that warranted a full abdominal examination which includes a rectal examination.

8.3 I am of the opinion that there was no breach of duty of care in not carrying out a rectal examination on the 16/5/2011, 25/5/2011 (Dr V) and 24/1/2013 (Dr S). On these occasions I am of the opinion that the Claimant's symptoms do not warrant a rectal examination.

9. REFERENCES

9.1 http://www.sign.ac.uk/pdf/sign126.pdf

EXPERT'S DECLARATION

1. I understand that my overriding duty is to the court, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.

2. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert is required.

3. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters which I regard as relevant to the opinions I have expressed. All of the matters on which I have expressed an opinion lie within my field of expertise.

4. I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.

5. Wherever I have no personal knowledge, I have indicated the source of factual information.

6. I have no included anything in this report which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.

7. Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.

8. At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification.

9. I understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.

10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

11. That I know of no conflict or interest of any kind, other than any which I have disclosed in my report.

12. That I do not consider that any interest which I have disclosed affects my suitability as an expert witness on any issues on which I have given evidence.

13. That I will advise the party by whom I am instructed if, between the date of my report and the trial, there is a change in circumstances which affect my answers to either of the above two points.

STATEMENT OF TRUTH

I confirm that I have made clear which facts and matters referred to in the report are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer.

Signature:

_____

Date:

_____