Medical report by Dr Oliver D Starr

Dated
5th Nov 20XX

Medical Field
General practice

Claimant
The husband of the late Mrs G, date of birth xx/xx/1954, formerly of Hull.

Defendants
The general practitioners of TT Medical Centre, Hull.

On the instructions of
Mr W, W & Co Solicitors, Leicester, representing the claimant. Your ref W/123/G.

Subject
The care given to Mrs G by the GPs of TT Medical Centre in relation to a low **platelet count** in Apr and May 2016 which transpired to be caused by **metastatic** breast cancer.

Written by
Dr Oliver Starr, Herts, UK.

Report

1. Introduction and summary

1.1 Summary

Mrs G was in reasonable health. She had a routine blood test, for no specific reason, in Apr 2016 which showed a slightly low **platelet** level of 75 (the normal range being 150-405). The test was repeated in May 2016 and came back again at 75.

Dr F, a GP at the surgery, documented she ought to have the test repeated in a month. There is a note in the records that Mrs G was telephoned twice to inform her of this, but that there was no answer.

It is not clear from the records if she was seen in person after that until she presented on 29th July 2017 feeling extremely unwell, too weak to walk and looking pale.

She was admitted to hospital that day where investigations showed she was very anaemic and the platelet count was now 41. Subsequent tests showed she had breast cancer which had spread around her blood stream and into her **bone marrow**.

Despite chemotherapy she died on 24th Sept 2017.

1.2 Summary of my conclusions

This report will show that in my professional opinion there was a breach of duty of care by Dr F because:

- He failed to ensure Mrs G was formally asked to have the full blood count repeated after May 2016, relying instead on a staff member telephoning her.
- He missed an opportunity to ensure the blood test was repeated when he made an entry in her notes on 8th Sept 2016.

There may have been a breach of duty of care by Dr C on 8th Sept 2016 depending on whether she saw Mrs G in person or simply made an administrative entry in the notes.

However:

- A persistently low platelet count of 75 should prompt a routine (not urgent) referral to a **haematologist** and would not normally indicate any serious illness.

- In my opinion a referral to a haematologist or other specialist was not warranted on receipt of the first test showing the platelets of 75 in Apr 2016, nor on receipt of the second test in May 2016 which also showed platelets of 75. However, a referral to a haematologist

would have been warranted had a third test, done in June or July 2016, shown a similar platelet level.

1.3 Sources and background to this report

This report has been prepared for the court after instructions from W & Co Solicitors and examination of:

- GP records of Mrs G from 3rd June 2010 until her death.
- Blood test results during that period.
- A discharge summary from the ABC Hospital.

1.4 In this report I will concentrate on the standard of care given by the general practitioners involved. I will not deal with the care given by hospital doctors nor deal with causation or prognosis. These are better dealt with by an appropriate consultant expert which in this case would be a consultant oncologist with an interest in breast cancer or a consultant haematologist.

1.5 I have never met Mr or Mrs G. Nor have I ever met or communicated with any of the doctors at TT Medical Centre.

1.6 Where I have used technical terms I have highlighted these in bold and given a plain-English explanation either immediately after the text or at the end of the report in the appendix.

2 The issues to be addressed and statement of instructions

I am in receipt of correspondence from W and Co Solicitors. The letters raise the issue of the low platelet level that was detected in Apr 2016 but not acted upon. I am asked to ascertain if the standard of care by the GPs, particularly Dr F, was below that expected of a reasonably competent GP.

3 The medical records

3.1 The GP records begin in June 2010 but the first pertinent record is from 9th June 2013 when Mrs G saw a doctor regarding a sore neck. The doctor (it is not clear in the records which doctor) prescribed the painkiller Kapake (which is co-codamol). It looks like Mrs G had been taking a **non-steroidal anti-inflammatory** medicine and the doctor wanted to check her **kidney function**, because these types of medications can damage the kidneys. A request was therefore made to have Mrs G's kidney function tested, along with her full blood count.

3.2 27th June 2013: Mrs G had the blood tests taken.

3.3 3rd July 2013: there is a note on the records that Mrs G was informed to have the bloods repeated in three months. It is not clear why this was. Mrs G did not have any further blood tests until Apr 2016.

There are then no entries in the records that are pertinent to this case until Apr 2016.

3.4 15th Apr 2016: had bloods taken for a full blood count, cholesterol and thyroid function. There is no reason given as to why she had a blood test. The records show she was contacted later that day with the results but there was no answer on the phone. An appointment was made to see Dr F on 18th Apr.

3.5 15th Apr 2016: The records available to me include a sheet from the GP surgery in which it is documented a phone call was received from the lab at the hospital. The lab had called the surgery to let them know Mrs G's platelet count was 75 (the normal range being 150-450).

[My original report included a scanned in image of the handwritten note by the practice receptionist, documenting the hospital phone call, which I have removed for reasons of confidentiality.]

There is also a note on the system of the low platelet level and high cholesterol, although it is not clear which doctor made this note:

5/04/2016	LOW PLATELETS, HIGH LIPIDS. PHONED NO ANSWER

3.6 18th Apr 2016: saw Dr F who advised a low cholesterol diet (Mrs G's cholesterol was slightly raised, at 6.8). He documented she was well with no symptoms and that he found nothing wrong on examination. No reference was made to the low platelet level. I have scanned in the relevant blood test results, available to me in the GP records, here (with my circle around the platelet count):

Specimen Number	00160284886	**Date Collected/Observed**	15/04/2016 15:11
Specimen Source	Blood	**Specimen Received**	15/04/2016 15:11
Body Site		**Diagnostic SSID**	Haematology
Specimen Additives		**Order**	FULL BLOOD CC
Laboratory	WinPath, AMNCH		

Test Name	Result	Units
HB	15.3	g/dl
RCC	4.94	x10^1
HCT	0.449	L/L
MCV	90.9	fl
MCH	31.0	pg
MCHC	34.1	g/dl
RDW	15.2	
PLT	*75	x10^9
WCC	10.6	x10^9

Other blood results from that day were a kidney function test (which was normal) and a liver function test which was normal (note is made in the solicitor's correspondence to the **ALP** level of 129, but in my opinion that is not significant).

Presumably Mrs G was told to have the bloods repeated because she had them done the next month.

3.7 16th May 2016: had bloods taken for full blood count, kidney and liver function, cholesterol, thyroid function and vitamins.

3.8 20th May 2016: a note on the system that Mrs G's **folic acid** level was low. This was because the folate level was 2.3, with the normal range being 3.3-17.

There is no mention of the platelet count which had come back low again, at 75. I have scanned in the results here (with my circling of the platelet count and date):

[My original report included a scanned in image of the blood results from the records which I have removed for reasons of confidentiality.]

Other bloods from that sample include an ESR of 25 (which is normal).

I have scanned in the entry from May 2016 (the exact date is obscured). It indicates a prescription was made for folic acid:

0/05/2016 RX FOLIC ACID

There is then an entry stating the full blood count (which includes the platelet count test) should be repeated in one month:

7/06/2016 RPT FBC 1/12

3.9 18th June 2016: a note that Mrs G was phoned twice (with no reply) to let her know to have the bloods taken again in a month, as per Dr F.

[My original report included a scanned image of the note in the records of these phone calls which I have removed for reasons of confidentiality.]

3.10 21st June 2016: a note that treatment was repeated for three months by Dr K. Again, it is not clear what this refers to.

3.11 6th Sept 2016: a note showing a blood pressure of 120/80 (which is normal).

3.12 8th Sept 2016: notes from Dr F showing the treatment was repeated for six months; and a note by Dr C regarding a medication check.

3.13 22nd June 2017: a note on the system that the treatment was continued for three months by Dr J.

3.14 29th July 2017: a note that Mrs G felt unwell and was too weak to walk. The doctor (it is not clear which it was) noted she looked pale but had clear lungs. They noted the history of low platelets and sent Mrs G to the emergency department:

29/07/2017	UNWELL , BP LOW, FEELING WEAK , NOT ABLE TO WALK , EAT DRINK OK , NO BLEEDING TENDENCY , ON FOLIC ACID PONSTAN, , BP 90/60 MMHG PALE CHEST CVS NAD HX OF BLOOD TESTS LOW PLATELES ,REFERRAL ED

3.15 The next GP record is on 22nd Aug 2017 which looks like a discharge summary from the ABC Hospital.

It documents how Mrs G was admitted with a very low **haemoglobin** of 6 and low platelets (documentation from the hospital shows her platelets were 41 at the time of admission). She had a **CT scan** of her chest, abdomen and pelvis, an **MRI scan** of her spine and a **mammogram**. The scans showed that she had a small cancer in her left breast which had spread to numerous bones in her spine.

Blood results from 29th July 2017, the day she was admitted, are scanned here. They show a low platelet level of 41 and a very low haemoglobin of 6.

INTERIM REPORT on 29/07/2017 at 17:24				Specimen
FULL BLOOD COUNT				
HB	6.0	g/dl	(11.5- 16.5)	LOW
RCC	1.65	x10^12/L	(3.8 - 5.8)	LOW
HCT	0.191	L/L	(0.360 - 0.460)	LOW
MCV	115.8	fl	(80 - 96)	HIGH
MCH	36.4	pg	(27.0 - 34.0)	HIGH
MCHC	31.4	g/dl	(31.0 - 36.5)	
RDW	23.0		(10.9 - 15.7)	HIGH
PLT	41	x10^9/L	(150 - 450)	LOW
WCC	15.7	x10^9/L	(4.0 - 11.0)	HIGH

The records show Mrs G received chemotherapy but despite this she passed away on 24th Sept 2017.

3.16 I have tabulated Mrs G's relevant blood results over the years.

Date	Haemoglobin	Platelets	White cell count
1/2/2010	15.1	181	7.5
27/6/2013	15.1	219	9.0
15/4/2016	15.3	75	10.6
16/5/2016	15.1	75	11.3
29/7/2017	6.0	41	15.7

4 My opinion

4.1 The first point to make is that a low platelet level in a sixty year old woman is not usually related to breast cancer, or any other type of cancer, as far as I am aware. In fact, an isolated low platelet count (where the other parameters of the full blood count test are normal) is not usually anything serious, in my experience. In addition, a level of 75 is not dangerous or life-threatening: a level of less than 30 might be considered serious by a GP and prompt a phone-call to a haematologist. But a level of 75 should prompt a repeat blood test in a month (as was done by the GP at TT Medical Centre).

4.2 There are dozens of reasons for a low platelet count. But from my point of view as a GP I think the most likely causes in a sixty year old woman are: a recent viral illness; a medication causing low platelets as a side-effect; or a non-cancerous condition called 'ITP' (idiopathic thrombocytopaenia: a condition in the blood which causes a low platelet level but is not usually serious). The other thing I would think about is laboratory error, hence the need to repeat the test.

If there were something more serious going on like a cancerous blood condition or bone marrow failure then usually the other parameters of the full blood count are also abnormal. There might be a low haemoglobin alongside the low platelet count or a high or low white cell count, for example.

A low platelet count by itself, without any other abnormal blood results, as was the case with Mrs G, does not normally signify anything serious. That does not necessarily mean it does not need actioning, or a referral to a specialist, but Mrs G's blood test results were not suggestive of cancer to me (nor, I am confident, to any other reasonable GP).

4.3 In my opinion therefore the management at the end of Apr 2016 was entirely reasonable: to repeat the full blood count in one month.

4.4 When the platelet count was still low, at 75, on 15th May 2016 it required actioning. In my view there is a range of opinion as to what that action might be. Some GPs might make a routine (not urgent) referral to haematology. The GP could expect the patient to be seen in three months, without due concern. This is, as I said above, because a platelet count of 75 without any other abnormalities on the blood tests, is not usually any cause for alarm nor indicative of any serious illness.

Some GPs may have simply repeated the full blood count a third time, perhaps in a month, to see if the platelet count was returning to normal or getting lower. If it were returning to normal and the other blood tests were still normal, that should prompt another repeat in a month or two. If the platelet count had got lower then that should prompt a referral to haematology, again on a non-urgent basis. If the level were very low, less than 30 approximately, the referral ought to be marked urgent.

Alongside this repeat testing or referrals ought to be advice to the patient to avoid aspirin and anti-inflammatory drugs like ibuprofen. This is because these drugs can interfere with how platelets work and render the patient prone to bleeding.

My opinion here is corroborated by published guidance: information on patient.co.uk (https://patient.info/doctor/thrombocytopenia-and-platelet-function-disorders) and an article in the British Medical Journal from 2013 (BMJ 2013;346:f11).

4.5 In addition to the blood tests, I would expect any competent GP to examine the patient and check for an enlarged liver or spleen in the abdomen or for any lymph nodes in the neck. The entry from 18th Apr 2016 by Dr F states '*o/e nad*' (meaning, 'on examination, nothing abnormal detected'). It cannot be gleaned from that entry what he examined for, but in my opinion it is reasonable to think he checked, as an experienced GP would, for glands in the neck and probably felt Mrs G's abdomen).

The lack of any abnormal findings by Dr F on 18th Apr 2016 corroborates my view that it was sufficient to repeat the full blood count in a month, rather than refer Mrs G to a specialist at that time.

4.6 Given the platelet count was the same in May, at 75, I think it was reasonable to repeat the test in a month. This was suggested in the records and I note that someone from the practice, in early June 2016, has recorded phoning Mrs G twice to inform her of the need for a repeat blood test:

[My original report included a scanned in image of the note in the records of these phone calls, but I have removed it for reasons of confidentiality.]

4.7 This entry suggests that Mrs G remained unaware of the need for a repeat full blood count, given that there was no answer on the phone from her. There is no suggestion in the records that the practice wrote to her or called her again.

In my opinion therefore the first breach of duty occurred here, by the practice not ensuring Mrs G was formally made aware of the need for a repeat blood test.

4.8 There are then at least two entries in the records which suggest Mrs G was seen in person: a blood pressure check on 6th Sept 2016 (it does not say whom entered the blood pressure values); and a 'meds check' documented by Dr Laura C.

It may be that the medication review by Dr C was done without seeing Mrs G. Similarly the entry '*repeat Rx 6/12*' by Dr F:

[My original report included a scanned in image of this record, but I have removed it for reasons of confidentiality.]

Nevertheless if Dr F typed an entry into the records in Sept 2016 I believe he had a duty to ensure the full blood count was repeated, as he had suggested in June. In my opinion that entry of Sept 2016 should have prompted a phone call or a letter to Mrs G, asking her to come in for another full blood count.

4.9 In my opinion Dr F's failure to ensure the full blood count was repeated after May 2016 represented a breach of duty of care.

4.10 I note Dr C's entry in Sept 2016 (the exact date is obscured) regarding a '*meds check*'. If Dr C saw Mrs G in person on that date that I would expect her to have glanced down at the preceding few months' records and notice the low platelet count. If that was the case, her failure to inform Mrs G of the need for the blood test represented a breach of duty of care.

If Dr C did not see Mrs G in person, but rather was simply making an administrative entry in the records, then in my opinion there was not a breach of duty. This is because it would not be incumbent on her to review the records and take on responsibility for chasing the repeat blood test. That responsibility would remain in that case with Dr F.

4.11 In addition to this, the standard of record-keeping is consistently poor such that in many cases it cannot be ascertained which doctor is making the entry. The poor record keeping does not necessarily constitute a breach of duty of care because it may be considered normal compared to other doctors in the area.

4.12 It is important to note however that even if a third platelet count had come back low, that may still only have prompted a routine (rather than urgent) referral to haematology. That referral may not have altered events for Mrs G, if the breast cancer had already infiltrated her bone marrow. An oncologist with an interest in breast cancer, or a haematologist, would be best placed to give an opinion on that.

5 Statement of conflicts

I confirm that I have no conflict of interest of any kind, other than any which I have already set out in this report. I do not consider that any interest which I have disclosed affects my suitability to give expert evidence on any issue on which I have given evidence and I will advise the party by whom I am instructed if, between the date of this report and the trial, there is any change in circumstances which affects this statement.

6 Statement of compliance

I understand my duty as an expert witness is to the court. I have complied with that duty. This report includes all matters relevant to the issues on which my expert evidence is given. I have given details in this report of any matters which may affect the validity of this report. I have addressed this report to the court.

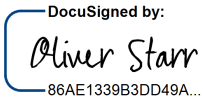
7 Statement of awareness

I confirm that I am aware of the requirements of Part 35, Practice Direction 35 and the Guidance for the Instruction of Experts in Civil Claims (2014).

8 Statement of truth

I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that 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.

I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.



Signed by Dr Oliver Starr

Appendix 1 My experience and qualifications

General medical council number 6102039

- General practitioner in Hertfordshire. My work involves visiting the elderly in their homes and making visits to care homes and nursing homes; working in an urgent care centre seeing patients of all ages; and working in traditional general practice surgeries. I qualified as a doctor in 2004, as a GP in 2009.
- Undergraduate tutor at University College London Medical School. I teach first year and second year medical students in small group tutorials. I have been doing this since 2013.
- Member of the NICE GP reference panel. This involves reading new or revised NICE guidelines and giving feedback on their applicability to general practice. This is unpaid.
- Case assessor for the National Perinatal Epidemiology Unit, Oxford. If a woman has died during pregnancy or in the year after giving birth, their records are scrutinised to see if more could have been done. I am part of a group of doctors that assesses cases where the woman's care has involved their GP. This is unpaid.
- Elected member of the Hertfordshire Local Medical Committee. The committee works to ensure the political landscape in general practice is benefitting the patient and is not putting barriers in the way of GPs delivering patient care.
- General practitioner appraiser. Every GP in the country has to have an annual appraisal. I am an appraiser for Hertfordshire and Bedfordshire, a role that requires assessment and annual training. I scrutinise the appraisee GP's learning activity for the year, discuss any learning needs they have and help them reflect on any complaints or incidents. I do about twelve appraisals a year.
- Former writer of medical articles for www.patient.co.uk

Qualifications

Cardiff University Law School Bond Solon Expert Witness Certificate (Civil) Apr 2020.

LLM	(Medical Law) University of Northumbria, 2017.
MRCGP	Membership of the Royal College of General Practitioners, 2009.
MRCS	Membership of the Royal College of Surgeons of England, 2009.
DRCOG	Diploma of the Royal College of Obstetricians and Gynaecologists, 2009.
MBChB	Bachelor of medicine and surgery, University of Birmingham, 2004.
BMedSc	Bachelor of science, University of Birmingham, 2001.

Appendix 2 Glossary of terms used

ALP: standing for alkaline phosphatase. A substance that is produced by the liver. If something is blocking the liver, the ALP level in the blood goes up which can be detected in a blood test.
Bone marrow: the inside of the bones, where blood cells are made. If there is a problem with the bone marrow the person may become ill because their blood will not be composed of the correct types of cells.
CT scan: standing for computerised tomography scan. A detailed scan which can be done of any part of the body. Only takes thirty seconds to perform.
Folic acid: a vitamin that is in most foods. A patient's folic acid level is tested for sometimes by general practitioners but its level is not usually important.
Full blood count: a frequently performed blood test which shows up the level of haemoglobin (which is an approximate measure of how much iron or blood there is in the body), the platelet count and the white cell count (which shows how well the immune system is working).
Haemoglobin: a substance in blood cells that we need to move oxygen around the body and help us breathe. If the haemoglobin is low it is usually because the person lacks iron or has lost blood in some way.
Haematologist: a hospital specialist who deals with problems with the blood. These could be cancerous conditions like lymphoma, or non-cancerous conditions.
Kidney function: meaning how well the kidneys are working. The same as 'renal function'.
Mammogram: a x ray of the breasts which is used to detect breast cancer. Takes about five minutes to perform.
Metastatic: refers to cancer when it has spread around the body, away from the original site. For example breast cancer can metastasise to the glands under the arm, or prostate cancer can metastasise to the bones in the lower spine.
MRI scan: standing for magnetic resonance imaging. A detailed scan which can now be done of any part of the body. Good at showing up tiny nerves, which may be squashed by a slipped disc for example.
NSAID: standing for non-steroidal anti-inflammatory drug. These are medicines like ibuprofen, diclofenac, naproxen and indometacin. They are commonly used as pain killers for sporting injuries or aches and pains. Their side effects include stomach ulcers and kidney damage, if used for prolonged periods.
Platelets**:** tiny cells that float around in the blood and help it to clot.
Thyroid function: a blood test to see how well the thyroid is working. The thyroid is a small gland in the front of the neck which cannot usually be felt.

Appendix 3 Academic texts referenced

Information on low platelet counts from patient.info available at https://patient.info/doctor/thrombocytopenia-and-platelet-function-disorders

Thachil J, Fitzmaurice D. Thrombocytopenia in an adult. BMJ 2013;346:f3407 available at https://www.bmj.com/content/346/bmj.f3407