

Inquest Into The Deaths of David Gray & Iris Edwards
Coroner's Summing Up, Decisions & Announcements

I come now to sum up and give my decisions:

This is an inquiry in to the deaths of David Gray and Iris Edwards both of whom died in February 2008.

David Gray was a retired electronics engineer who was born on the 2nd May 1937 and who was living with his partner, Lynda Bubb, at 12 Cathedral View, Manea, Cambridgeshire. At the time of his death on the 16th February 2008 he was aged 70.

Mr Gray apparently suffered from renal colic. We learn, for example, from Dr Hirson his GP that Mr Gray had a history of kidney stones, although no stones were found at post mortem examination. In all events, Mr Gray was a frequent user of NHS services as he suffered frequent episodes of pain. I have no doubt on the evidence that he was somewhat of a demanding patient. Indeed, I learn from Miss Bubb that how Mr Gray reacted to his medical difficulties put her under stress and pressure.

Dr Hirson his GP tended to treat Mr Gray with pethidine, at a dosage of 100mg. On many occasions between 2006 and 2008, however, Mr Gray was treated, not by his GP, but through the out of hours services.

Through such services he had injections at various times of pethidine or diamorphine, the diamorphine doses being at 10mg. Mr Gray would also drink alcohol to help alleviate his symptoms.

On the 16th February 2008 David Gray was in discomfort. He had diarrhoea around mid-morning and he took brandy. When Miss Bubb proposed preparing food around lunch-time, she was told by him to forget about food and to call out of hours services as he was apparently in severe pain. She telephoned out of hours services and was shortly after telephoned back. It was suggested to her that David Gray be taken to the community hospital in Ely. Lynda Bubb said she could not do this because of her own reduced mobility at the time and the degree of David Gray's pain. she was told that a doctor would come round to their home in about 2 hours.

During the afternoon, Lynda Bubb was just about to telephone the out of hours services again, when a doctor arrived. This was Dr Daniel Ubani, who arrived in a car provided by the out of hours services and driven by Lesley Dent.

Lynda Bubb described Dr Ubani as black, probably in his 50s and he seemed in good health. Although when Lynda Bubb was questioned by Miss Hewson, she said of Dr Ubani that he seemed tired and not as alert as he should be.

Dr Ubani saw David Gray in the bedroom at the back of the house. He seemed a bit dithery and muttered. Lynda Bubb told Dr Ubani that in these situations David Gray

received 100mgs of pethidine, and David Gray confirmed this. She also explained to Dr Ubani that there were situations where the out of hours services did not carry pethidine and in those circumstances diamorphine was used. I have little doubt that the mention of 100mgs influenced Dr Ubani in the gross error he was to make. At some stage during the visit Dr Ubani went to the car and returned with a green box – obviously the Palliative Care Box.

Lynda Bubb did not see Dr Ubani examine David Gray or take his pulse or blood pressure but she admits she was absent for about a 5 minute period.

She saw Dr Ubani pull out an ampoule from the green box. She says she saw the doctor look at a card, but apparently not at any instructions. She doesn't remember him actually loading the syringe, but explains he was at the window with his back to her.

She witnessed Dr Ubani administering two injections, one after the other, one in each buttock of David Gray. One injection was the diarmorphine for the pain relief and the other Buscopan as an anti-emetic.

David Gray thanked Dr Ubani. The doctor was downstairs, to complete records and then left. He did not re-examine or check on the patient. He left detritus including the two syringes on the window sill.

We know from the records that the diamorphine administered was at 100mg, by intra-muscular injection, at 16.45 hours on 16th February 2008. The Buscopan was at 4mg also by intra-muscular injection.

Lynda Bubb in due course checked on David Gray a couple of times, in due course realising something was terribly wrong. She called emergency services. Two paramedics arrived with an ambulance from Wyton in about 20 minutes and a third paramedic by motorbike shortly after. David Gray's life was pronounced extinct at 18.36 hours – just after twenty five to seven.

Dr Cary's Post Mortem Report on David Gray reveals the cause of death to be:

- 1a) Diamorphine poisoning in association with alcohol intoxication.
2. Hypertensive heart disease and myocardial fibrosis.

He says, however, that given the large dose of diamorphine, there is in fact no need to invoke the additional effect of alcohol in causing death. I understand from evidence heard that the diamorphine dosage of 100mg, was possibly at least 10 times the normal therapeutic level. Dr Cary confirms that there was no evidence that the deceased was substantially tolerant to the use of opiate drugs.

The hypertensive heart disease and myocardial fibrosis as a cause is given at 2. Significantly it is not at 1b).

I am satisfied as a matter of causation that David Gray died as a result of the administration of 100mgs of diamorphine.

Iris Edwards was a widow, an elderly lady, living at Vera James House, Chapel Street, Ely. She was born on the 11th April 1921 and at the time of her death, on the 17th February 2008, was aged 86. She was in poor health. I understand from a report from Dr Mee of St Mary's Surgery, Ely, that Mrs Edwards had been living in sheltered accommodation. She then had an episode of hospitalisation and it was then felt unsafe for her to remain in sheltered accommodation. She therefore moved to Vera James House in September 2007. Her mobility was restricted and she was becoming increasingly frail.

She became more unwell on the 16th February 2008. After lunch time that day she was observed suddenly to look pale and clammy and more confused than usual. She was put to bed and a decision made that she should receive a home visit from a doctor.

Dr Ubani attended at 18.07 hours. He prescribed Verapamil 80mg and Oxozepam 10mg and then left. He did not arrange for her to be admitted to hospital. Before these drugs could be obtained or administered she deteriorated further. At 2 a.m. the 17th February she was checked by a carer, when her breathing was a bit erratic, but no pain. A quarter of an hour later at 02.15 hours she was checked again. She was not breathing and presumed dead.

Dr Mongwa attended as a house visit and confirmed death at 03.25 hours.

Dr Cary's Post Mortem Report on Iris Edwards shows the cause of death to be:

- 1a) Recent myocardial infarction.
- 1b) Ischaemic heart disease.
- 1c) Coronary artery thrombosis and atherosclerosis.
- 2) Left ventricular hypertrophy due to hypertension and aortic valve incompetence.

Dr Cary has said in evidence that he considers the onset of the myocardial infarction (or death of the heart muscles) occurred in the 24-48 hours previously.

He says that had the deceased been admitted to hospital by Dr Ubani prognosis would have improved because of the much greater ability to deal with potentially fatal heart rhythm disturbances in hospital. He does also say that he is unable to state with certainty that the deceased would have not died around the time she did even if she had been admitted to hospital. He says "it is however more likely than not that she would have survived at least in the short term."

The two deceased were not the only patients attended by Dr Ubani. The records show that over the weekend of the 16th February and 17th February 2008. Dr Ubani consulted face to face with 13 patients and gave advice by telephone to 5 more.

Included in the face to face consultations were visits Dr Ubani also made to Phyllis Fletcher and Sandra Banks.

Some time after midday on the 16th February, Dr Ubani attended Phyllis Fletcher a lady who had severe chronic obstructive pulmonary disease. She was having breathing difficulties. Dr Ubani prescribed Simple Linctus 200ml, Uniphyllin Continus 200mg capsule. There is no evidence that this prescription harmed her in any way, but the patient's doctor, Dr Carol Walcott, has made a statement severely criticising Dr Ubani's treatment. I will not rehearse all the criticisms, but she thinks Dr Ubani should certainly have assessed the patient properly to determine whether or not she could be treated at home or hospital and in any event if not admitted to hospital arrange a review of the patient in a few hours.

A little later that day in the mid afternoon Dr Ubani visited Sandra Banks at 15 Steward Close, Stuntney near Ely. She suffered from temporal arteritis and had bad migraines. That day she was suffering from headache and nausea. Dr Ubani injected her with Furosemide, a diuretic. He left, but the patient did not improve and was in due course admitted to hospital.

I have heard evidence from Dr Saywood who has given his opinions as to the competency or otherwise of Dr Ubani in his treatment of the two deceased and of Sandra Banks. His opinions are as follows:

In respect of David Gray, he says it would be unusual to treat renal colic with diamorphine. An appropriate sized dose of diamorphine would be 5-10mg and that the actual dose administered was 10 times the recommended dose. He says that for Dr Ubani to leave the patient alone after giving the drug and without checking on him was a dangerous practice. He says he should have consulted colleagues and he did not show full competence.

In respect of Iris Edwards, Dr Saywood says that Dr Ubani failed to assess the patient fully, he failed to take appropriate action which was to admit her to hospital, and he failed to consult colleagues. He says Dr Ubani's care of Mrs Edwards was inadequate.

In respect of Sandra Banks, Dr Saywood says Dr Ubani gave an injection of Furosemide, a diuretic that was contra-indicated in a patient who was probably dehydrated. He also voices other criticisms.

It is clear to me that Dr Ubani in his dealings with patients over that fateful weekend was Incompetent – not of acceptable standard. I will return to this issue later.

I deal now with Dr Ubani's movements that weekend and how he came to be in this Country.

At the time Dr Ubani was aged 65 years, having been born in Nigeria on the 22nd July 1942. His CV suggests he was schooled in Nigeria and went to Universities in Russia

and Germany. His registration with this country's General Medical Council is the 27th October 2006, with entry on to the GP register on the 2nd November 2006.

His services were engaged by an agency called Cimarron UK Ltd who supplied his services to Take Care Now, a limited company that provided services to Suffolk Doctors on Call Ltd. In turn Suffolk Doctors on Call provided Out of Hours Primary Medical Services to NHS Cambridgeshire. NHS Cambridgeshire was another name of Cambridgeshire Primary Care Trust. Prior to 2006 there had been in the area a number of smaller PCTs, the relevant one for the area concerned being East Cambs & Fenland PCT.

Returning now to Cimarron: this company engaged Dr Ubani to provide his services, to be based in Newmarket for the weekend 16th February and 17th February 2008, and the weekend 23rd February and 24th February 2008, his hours to be 8 a.m. to 7.59 p.m. (in effect 8 p.m.): a twelve hour day on each day. He was to be paid £45 an hour and he was to pay for his own accommodation.

In pursuance of such agreement Dr Ubani flew from Germany, arriving at Stansted airport on the morning of the 15th February 2008.

He then hired a car and travelled to the offices of Cimarron in Little Horksley, Colchester, arriving at about 2 p.m. There he was met by Sharon Brooks, a company director of Cimarron. With her he did not receive induction or training, but had a conversation relating to such matters as the key locations in the area and how to get to

them. To Sharon Brooks Dr Ubani appeared a lot younger than his age and fit looking. A Dr David Wood from the company also sat with Dr Ubani at a computer and obtained directions to several key locations. Sharon Brooks gave Dr Ubani a copy of the October 2007 MIMS, the Monthly Index of Medical Specialities. Dr Ubani left Cimarron's offices at about 4.30 p.m., with the MIMS and also Sharon Brooks's personal satellite navigation system she lent him.

He arrived at 6 p.m. at the offices of Take Care Now at Riverside Clinic in Landseer Road in Ipswich. There he was seen by Karen Byford of TCN, one of whose roles was a support trainer, training clinicians and nurses. This was training in the Hampshire Medical Services (or HMS) computer system. It was not clinical training. Karen Byford said Dr Ubani did not appear tired, and that she had no problems communicating with him. She did say, however, that normally the session with the doctor would take about one and a half hours. Dr Ubani, though, found it necessary to make a lot of notes and the session ended up taking about two hours, until about 8 p.m.

There then followed an induction session, given to Dr Ubani by Dr Uzokwe. It appears this session lasted from about 8 p.m. to about 9.50 p.m., although during that time Dr Uzokwe would have had interruptions on his time. Dr Uzokwe is a GP in practice, of considerable experience, and he also works part time for TCN. An e-mail sent to him a short while before, asking him to conduct Dr Ubani's induction, he had not had the chance to read. He was therefore caught by surprise, and indeed he already had with him

a female Registrar who was shadowing him. Clearly, these were not auspicious circumstances for any such induction.

Dr Uzokwe felt that the interaction he had with Dr Ubani was the same as with any other normal doctor. There were no problems with the English Language.

What Dr Uzokwe was concerned about was that Dr Ubani had had no experience working in the NHS system, and that he was not used to the area. Dr Uzokwe did not have the chance to see Dr Ubani actually using the HMS computer system, but he, Dr Uzokwe, took him through the use of the system in how to deal with, for example, prescriptions, referrals, recording of clinical findings etc., Dr Ubani seemed to know all these things – assenting verbally – to questions.

Dr Uzokwe used a check list provided, making ticks for areas covered. These included matters such as prescription arrangements, the contents of the car boot, location of hospitals in the area, the call process system including 999 calls, and other matters, including to whom Dr Ubani could refer, if need arose.

One of the items dealt with was the Palliative Care Box. I will deal a little later with the evidence surrounding the Palliative Care Box and other items that were carried in the on-call doctor's car. Dr Uzokwe has told us that he did go through with Dr Ubani the documentation and instructions relating to the Palliative Care Box. Crucially, in my view, however, no actual box was produced at that induction session. This means it is

highly unlikely that Dr Ubani would have seen the document that lives inside the sealed box that contains details of Opioid strengths. Also Dr Ubani would not have had the chance, at that time to see the respective sizes of vials. He would not have been able to see that the 100mg vial of diamorphine was several sizes larger than the others.

Apparently at that induction there was no discussion about the use of diamorphine, nor was anything said by Dr Ubani of the use or otherwise of diamorphine or other pain killers in Germany. Nor was there any discussion about Naloxone, the drug antagonistic to diamorphine.

Dr Uzokwe was required to complete a Doctor Induction Report. Again this was simply a tick box checklist a page long. I have already mentioned Dr Uzokwe's concerns as to Dr Ubani's lack of familiarity with the NHS, or the area. On the Doctor Induction Report under Comments Dr Uzokwe wrote "I was not happy being asked at short notice to assess a fellow doctor without protected time. The time is too short I was also covering 2 NPs (nursing practitioners), a registrar shadowing me and in the middle of it asked to do an urgent visit. His English is of high standard but the assessment is not enough to assess his competence."

I take the crucial words to be "the assessment is not enough to assess his competence."

I understand that the completed form was not submitted until the Monday, 18th February 2008, that is after the sad events I inquire into. Take Care Now have not spoken directly to Dr Uzokwe about that report.

Dr Ozokwe confirms to me that the session with Dr Ubani was an induction only and that Dr Ubani received no mentoring. Indeed on his calls he was to be accompanied by a driver only.

It is unlikely that Dr Ubani would have left TCN's offices in Ipswich before 10 p.m. He then had to travel to his accommodation in Linton Close, Newmarket, and he did not arrive there until 00.40 hours – twenty to one in the morning – of the 16th February 2008. In his letter to the Gray family of the 10th July 2008 Dr Ubani indicates he was under a tremendous stress situation. He says he did not arrive in Newmarket until 4 a.m. on 16th February and had only 3 hours rest. I am inclined to accept the information given by his landlady to the police officer that arrival at Linton Close was probably at 00.40 – twenty to one. However whatever interpretation is placed, it had been a very very long day for Dr Ubani. In his letter he refers to a tortuous journey to Newmarket.

Let me say now, on the evidence, I consider the familiarisation process and induction process provided to Dr Ubani to have been for him insufficient. Indeed I think it was inadequate. I have no doubt that, taking also into account his age, he was tired out when he left his lodgings in the morning at 8.30 a.m., to begin work.

A possible pointer to the inadequacy of the familiarisation and induction process and to the lack of competency of Dr Ubani, is contained in the evidence of Carol Leonard. She was a nurse working at Newmarket Hospital for TCN on a morning shift on Sunday the 17th February 2008. So concerned did she become as to questions put to her that morning by Dr Ubani, that she reported such concerns to TCN. In particular she had been taken aback by his lack of knowledge about a very common drug, Ibuprofen, and about help he needed from her in filling out a prescription for a patient with breathing problems when he had not even at that point seen the patient. It appears, however, nobody came back to her about her concerns.

I deal now with evidence as to the items of medical equipment in the car in which Dr Ubani was driven, when making his calls and to the actions he took in relation to the Palliative Care Box.

In the car, I understand the boot, were the Black Lockable Bag (or Pilot bag) holding diagnostic equipment and drugs, the Silver Box stocked with drugs and medication, the British National Formulary and the sealed Palliative Care Box (which was in the Pilot bag). Dr Ubani had, presumably, his copy of MIMS.

Helen Palmer tells us that although the Pilot bag contained injectable drugs, it did not contain controlled drugs.

The Palliative Care Box did contain controlled drugs. As I have said it was sealed, in fact with a yellow seal, and a red seal. Attached to it – that is to say actually stuck to the outside of the lid was a form entitled Suffolk Doctors Palliative Car Drug Box. It lists ampoules containing various drugs and sodium chloride and water, the list starting with Cyclizine 1ml, Diamorphine 10mg, Diamorphine 30mg and Diamorphine 100mg and then other entries.

Attached in a plastic envelope or covering were a Palliative Care Order Form, for the doctor to complete, so that if he used a vial from the box, it could in due course be appropriately re-stocked. There was also a Form headed Doctors Palliative Care Box Instructions giving on one page clear instructions to the doctor on the steps he should take in using the box, including the recording of his use of any of the vials, and their re-ordering.

After breaking the seals and opening the box, Dr Ubani would have found inside a document headed Opioid Potency Ratios. It lists various drugs with diamorphine being the fifth one down. On the right hand column is given the relative potency of the drug concerned to oral morphine. The right hand column for morphine is therefore given as One. The right hand column for diamorphine reads 3.

Inside the box the vials, or ampoules, of drugs sat in recesses in a foam bed. All appear the same size except for one much much larger vial that sits at the top. This is the vial of

100mg of diamorphine and this is the one Dr Ubani selected and used to inject David Gray.

Following the treating of David Gray Dr Ubani went on that day of the 16th February 2008, to visit Iris Edwards, and then other patients.

On the 17th February 2008 Dr Browning, the clinical governance lead at Take Care Now and Suffolk Doctors On Call, received a telephone call from Trevor Maynard, senior duty manager at Take Care Now. This was at about 2.15 p.m. and it alerted him of a potential problem in which a patient had died. Dr Browning immediately put in hand checks and enquiries and stood Dr Ubani down, speaking to him by telephone at about 4.30 p.m. He advised Dr Ubani to return home to Germany. Dr Ubani was devastated.

In due course the General Medical Council, having been alerted, referred the matter to its Interim Orders Panel. This Panel first sat to consider the matter of David Gray's death on the 29th February 2008, and as a result suspended Dr Ubani.

The Panel has met further at different dates, on each occasion suspending the registration of Dr Ubani. That remains the position, with the next hearing due to take place on the 25th May this year.

On the 20th March 2009, arising out of the death of David Gray, the District Court of Witten in Germany imposed upon Dr Ubani a suspended prison sentence of nine months

for having caused death through negligence. Extradition of Dr Ubani to this country was refused. Dr Ubani has declined to attend this Inquest.

All that we have heard raises the worrying question: How was it that a doctor, who did not obtain his qualifications in this country, whose first language was not English, who was probably fatigued, who had received a less than adequate induction, and who was unfamiliar with the NHS system, and who did not know the area, came to be treating patients in Cambridgeshire, and treating at least some of them ^{incompetently?} ~~incompletely?~~ How was this lamentable situation reached?

The root of the problem may well lie with the EU Council Directive of the 5th April 1993 – Directive 93 – whose aims are to “facilitate the free movement of doctors and the mutual recognition of their diplomas, certificates and other evidence of formal qualifications.”

Either Dr Ubani had obtained what is known as “acquired rights” to practice in Germany or he had qualified formally as a GP in Germany. Either way, his status registration was a legal right in this country.

This meant that he could apply to go on a Performers List of a PCT in this country.

Article 20(3) of the EU Directive provides that member states “shall see to it that, where appropriate, the persons concerned acquire, in the interests of their patients, the linguistic

knowledge necessary to the exercise of their profession in the host country.” It seems in the case of Dr Ubani that the General Medical Council did not use this provision as part of their screening process.

So Dr Ubani was free to apply to go on a PCT’s Performers List in this country.

On a form dated 28th December 2006 Dr Ubani applied to go on to the Performers List of West Yorkshire NHS Central Services Agency. In support he supplied such documents as a reference, CV, insurance details, proof of registration with the GMC, evidence of lack of criminal convictions and other documents. However, the West Yorkshire authority required the passing of an International English Language Testing System (or IELTS) test. This required an overall score of 7 and Dr Ubani could only attain 6. He was obliged to abandon his application to that Authority’s Performers List.

Undeterred, by form dated 31st May 2007, Dr Ubani made application to go on the Performers List of the Cornwall and Isles of Scilly Primary Care Support Agency. Similar forms were produced as those that accompanied the previous application to West Yorkshire such as references, insurance details, a certificate of good standing and registration with the GMC. The GMC in its correspondence with the Cornwall and Isles of Scilly authority wrote to it on the 3rd November 2007 stating “I confirm Dr Ubani is exempt from UK vocational training requirements for general practice under Regulation 5(1)(g) of the National Health Service (Vocational Training For General Practice)

Regulations 1997 by virtue of his German certificate of specific training for general practice, which was awarded to him on 29 April 1995”.

The Cornwall and Isles of Scilly authority demanded no passing of any IELTS language test – nor did it make enquiries as to whether Dr Ubani had ever failed such test. On the 18th July 2007 the authority wrote to Dr Ubani approving his application to their Medical Performers List with immediate effect.

Being on one Performers List then enabled Dr Ubani to work for any PCT in England notwithstanding Regulation 6(2)(a) of the Performers List Regulations. I should explain that Section 6(2)(a) states that a PCT should refuse an application if it does not have satisfactory evidence that the applicant intends to perform his services in that PCT’s area. But being on the List did not restrict him to Cornwall and the Isles of Scilly. Thus it was that Dr Ubani was engaged by Cimarron to work for TCN for weekends in February 2008, with tragic consequences.

I have heard evidence of remedial steps that have since been taken both by NHS Cambridgeshire and by Take Care Now/Suffolk Doctors On Call. Much has been done but weaknesses remain in the system. These remaining weaknesses will attract announcements by me under Rule 43 of the Coroners Rules.

Dr Browning was e-mailing colleagues on the 15th January 2008 about his concerns over the use of Palliative Care Boxes and that there had been two cases where overdoses of 30mg of diamorphine had been given (happily no fatalities had occurred). He advised in

a discussion paper dated the 15th January 2008 that he considered separating high doses for syringe drivers, from other appropriate doses of an opiate for use in the acute situation. He advised further restriction of the use of the Palliative Care Box, and the provision of a smaller Pain Relief Box, along with a referee system in situations where the Palliative Care Box had to be used. The referee system would involve permission being obtained from the duty manager at base before the on call doctor could open the Palliative Care Box.

Dr Browning's suggestions were not put into effect before the 16th February 2008, but I bear in mind that his suggestions pre-date the tragic incident by only a month. Immediately after the incident the referee system was put in place, followed by introduction in due course of a separate Pain Relief Box. Cambridgeshire NHS has also required appropriate separation of high doses for syringe drivers from other acute pain relief doses. It has as a further step required removal of the 100mg dose of diamorphine from Palliative Care Boxes. It has in fact recently changed the out of hours provider from Suffolk Doctors On Call/TCN to another out of hours provider for this area.

I come now to deal with Verdicts. I will furnish Inquisition Forms. Paragraph 3 thereof will contain details of the time, place and circumstances of the relevant death. Paragraph 4 in each case will contain a short form verdict.

I deal first with the death of David Gray. I must consider whether unlawful killing is the appropriate verdict.

I look at causation. I am satisfied that the injection of 100mg of diamorphine was what killed David Gray. This, by his own admission in various letters and e-mails, was administered by Dr Ubani. The actions of Dr Ubani killed Mr Gray.

Although Dr Ubani selected the 100mg vial of diamorphine from the box, and after having injected the drug, he completed the records to show this, I am quite satisfied he did not mean to kill Mr Gray.

That said, has the killing come about through negligence, and, if so, was such negligence gross?

For there to be negligence, there has to be a duty of care. There clearly was such duty, owed by Dr Ubani as treating physician of his patient.

Was the negligence gross? I take into account the imperfect induction of Dr Ubani, his lack of familiarity with the NHS and the systems he was operating, and the fact that he was probably tired. Even so, those factors do not exculpate him from gross negligence. If he did not know the properties or size of the drug he was administering, he should not have administered it. He had the British National Formulary to consult, stuck on the lid of the box was a list of the drugs, attached to the box were instructions and inside the box was a list of opioid strengths. The vial he selected was far larger than any of the other vials, and if he had any doubts or queries I am satisfied he knew he could seek advice.

Nonetheless, he went ahead and injected the fatal overdose. This was gross negligence manslaughter.

Accordingly the verdict I return is "David Gray was unlawfully killed."

My Inquisition Form at Paragraph 1, being the name of the deceased, shows David Gray.

Paragraph 2, being injury or disease causing death, shows:

Ia) Diamorphine poisoning in association with alcohol intoxication.

II Hypertensive heart disease and myocardial fibrosis.

Paragraph 3, being time, place and circumstances at or in which injury was sustained, shows:

David Gray died on the 16th February 2008 at his home at 12 Cathedral View, Manea, Cambridgeshire, of an overdose of 100mg of Diamorphine, such overdose having been administered by an out of hours doctor from Germany."

Paragraph 4, being Conclusion of the Coroner as to the death, shows:

David Gray was unlawfully killed.

There then follows the details at Paragraph 5 required by the Registration Service.

I now deal with the verdict in respect of the death of Iris Edwards.

I have heard expert criticism of Dr Ubani's treatment of Iris Edwards, particularly indicating that he should have arranged for her to be admitted to hospital. Nevertheless, I have to take into account her age and that she was gravely ill. Indeed she had suffered within the previous twenty four to forty eight hours from an acute myocardial infarction. I am not satisfied on the evidence that admission to hospital would necessarily have saved her. I am returning a verdict that Iris Edwards died from natural causes.

My Inquisition Form at Paragraph 1, being the name of the deceased, shows Iris Edwards. Paragraph 2, being injury or disease causing death, shows:

- 1a) Recent acute myocardial infarction
- b) Ischaemic heart disease
- (c) Coronary artery thrombosis and atherosclerosis.
- II Left ventricular hypertrophy due to hypertension and aortic valve incompetence.

Paragraph 3, being time, place and circumstances at or in which injury was sustained, shows:

Iris Edwards died on the 17th February 2008 at Vera James House, Chapel Street, Ely, Cambridgeshire of natural causes, namely:

- 1a) Recent myocardial infarction, 1b) Ischaemic heart disease, 1c) Coronary artery thrombosis and atherosclerosis and II Left ventricular hypertrophy due to hypertension and aortic valve incompetence.

Paragraph 4, being Conclusion of the Coroner as to death shows:

Iris Edwards died from natural causes.

I deal with my power under Rule 43 of the Coroners Rules 1984 to make an announcement. Rule 43 is headed "Prevention of Similar Fatalities". The body of the Rule reads "A Coroner who believes that action should be taken to prevent the recurrence of fatalities similar to that in respect of which the Inquest is being held may announce at that Inquest that he is reporting the matter in writing to the person or authority who may have power to take such action and he may report the matter accordingly."

I shall indeed make a report to the Secretary of Health suggesting the following actions be taken:

- 1) Having regard to specific training in medical practice, and the variation in status of general medical practitioners across member states of the EU, that he undertake a review of the operation of the Council Directive 93/16/EEC within the United Kingdom.

- 2) Guidance be given to all PCTs reminding them that each PCT must be satisfied under Regulation 6(2)(b) of the National Health Service (Performers List) Regulations 2004("Performers List Regulations") that each PCT must be satisfied that performers have a sufficient knowledge of English to be able to work as a doctor.

- 3) Guidance be given to all PCTs that in assessing applications to join performers lists they must be able to demonstrate that they have applied Regulation 6 of the Performers List Regulations robustly, and that they have an appropriately qualified person responsible for ensuring that this is done in each PCT.
- 4) Steps be taken to ensure that each PCT follows a nationally drawn up protocol (to avoid variation in standards) before deciding to admit a practitioner to a performers list.
- 5) Steps to be taken to remind PCTs that it is a mandatory requirement under Regulation 6(2)(a) that the PCT concerned must be satisfied that performers intend to deliver services in its area.
- 6) Guidance be given to PCTs recommending that PCTs should, when considering an applicant's suitability to join the Performers List, consider whether he has failed to progress other applications by him to other PCTs, and whether any such other applications have been turned down.
- 7) That guidance be given to all PCTs requiring risk assessment in respect of every non-UK based doctor in out of hours care such risk assessment to include assessment of a) the doctor's degree of experience of working in the NHS, b) whether the doctor gained accreditation to do general practice in his home state under any acquired rights system, rather than by examination or accreditation.

8. That guidance be given to PCTs ensuring that quality assurance in recruitment should be the responsibility of the relevant out of hours provider and should not be delegated to commercial agencies who provide doctors.
9. That there be guidance to ensure that all PCTs have written contracts with their out of hours provider, containing detailed requirements concerning standards to be observed by out of hours providers in the recruitment, training and induction of staff for out of hours work, and that such contracts have robust clinical governance and risk management structures in place.
10. That there be guidance to ensure that all contracts between PCTs and their out of hours providers are regularly and robustly monitored to ensure quality service standards.
11. That the Department of Health institute a national database of doctors from abroad who apply for inclusion on any performers list, such database to hold information on language skills, levels of medical competence (including qualifications and appointments), criminal record checks and records of any malpractice, and whether any doctor has been registered by, or had withdrawn his application to any PCT.

I shall also make a report to the following:

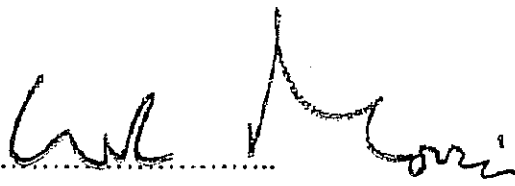
1. The Strategic Health Authority of this area suggesting it should recommend to all out of hours providers that no doctor should undertake out of hours work unsupervised, unless he has been through a proper induction with a clinician employed by the same out of hours provider who has been suitably trained in undertaking inductions.
2. To the Royal College for General Practitioners inviting it to draw up a national training and assessment programme for doctors, qualified abroad, who have never worked in general practice in the United Kingdom.

I come now to close. I thank the advocates for their considerable assistance in this matter. I thank the witnesses who have attended, and wish to express my sincere condolences to both families of the deceased.

A written copy of these findings and announcements will now be released.

Thank you all for your attendance. These proceedings are closed.

Signed

Handwritten signature of W R Morris in black ink.

W R Morris

HM Coroner for North & East Cambridgeshire.

Dated

04/02/10