SPSO decision report

Case: **201200184, A Medical Practice in the Ayrshire and Arran NHS Board area**
Sector: health
Subject: clinical treatment; diagnosis
Outcome: upheld, recommendations

Summary

Mr C complained that when his late father (Mr A) went to his medical practice in December 2011 they did not fully assess his condition and showed a lack of urgency in following up with his father. Mr A had a history of myeloma (cancer of the bone marrow) and had received treatment, including a stem cell transplant, between 2009 and 2011. In late 2010 and in November 2011 Mr A was told there was no trace of the disease left.

In late November and early December 2011 Mr A started to complain of breathlessness, weight loss, decreasing energy levels and back pain. His son and wife were concerned and persuaded him to speak to his GP on 6 December, as he was due to attend the practice that day for blood tests. Mrs A accompanied Mr A to the surgery and when she realised that Mr A was only due to see the practice nurse for the blood tests, asked that Mr A be seen by a GP.

One of the GPs (not Mr A's regular GP) saw Mr A as an emergency appointment. Although they examined him and made notes, our investigation found that there was no record of the presence or absence of anaemia (iron deficiency) or of the standard observations of pulse, temperature, respiration rate etc that would be expected for a patient reporting the symptoms that Mr A was suffering. The GP diagnosed a chest infection and prescribed an antibiotic. He told Mr A to make a follow-up appointment for seven days time, at which blood tests would be taken if there was no improvement in his symptoms.

Mr A forgot to make the follow-up appointment but six days later his son was so concerned that he tried to speak to Mr A's regular GP but was unable to do so. He did manage to speak to her the following day and she arranged urgent blood tests. The laboratory that conducted the tests were so concerned by the results that they contacted the local out-of-hours GP service that evening. A GP reviewed the results and notified the practice, but considered that a full GP review could wait until the next day. Mr A saw his regular GP, who immediately advised him to go to the local hospital and called ahead to make arrangements for him to be seen there. Mr A was admitted, but died in hospital the next day.

We upheld Mr C's complaint. Our medical adviser said that the GP should have had further blood tests done on 6 December, with a GP review on receipt of the results. The blood test that the practice nurse had taken was to check Mr A's cholesterol level and would not have told the GP anything about his condition or the cause of the symptoms Mr A complained of. The adviser also said that while it might have been reasonable for the GP to prescribe the antibiotic, the fact that he suspected an infective condition should have rung alarm bells in a patient with Mr A's history of myeloma. He thought that the symptoms Mr A was reporting should have triggered a more robust follow-up.

Recommendations

We recommended that the practice:

- issue a written apology to the family of the late Mr A;

- ensure that the GP conducts a significant event audit, to be discussed at his next appraisal; and
- conduct a review of a sample of clinical records to ensure that consultations are appropriate and accurately and fully recorded.