Scottish Public Services Ombudsman Act 2002

Report by the Scottish Public Services Ombudsman
of an investigation into a complaint against:

CADOC Ltd (Coatbridge and Airdrie Doctors On Call)
Lanarkshire Primary Care NHS Trust

Complaint as put by Mr B

1. The account of the complaint provided by Mr B was that at around midnight on 6 April 2000 his wife began having difficulty breathing. Mr B telephoned CADOC (CADOC is a co-operative of general practitioners (GPs) which provides an out-of-hours service to NHS patients). The receptionist told him that a doctor would call. The GP on duty (the GP) telephoned him and the only thing he asked was whether Mrs B was mobile. Mr B explained that she was not very mobile and tried to emphasise their age (both were aged 75) but the GP urged him to bring Mrs B to the surgery. While he was helping her down the stairs, Mrs B collapsed. With the help of a neighbour Mr B lifted his wife into his car then drove her to Monklands Hospital Accident and Emergency department. Mrs B did not regain consciousness and died on 8 April. On 2 May Mr B complained to CADOC about the care and treatment provided for Mrs B. After meetings and exchanges of correspondence Mr B remained dissatisfied. On 13 February 2001 he asked Lanarkshire Primary Care NHS Trust's convener to have his complaint considered by an independent review panel. The convener turned down the request.

2. The matters investigated were that:

(a) the GP did not obtain sufficient information from Mr B to put himself in a position to assess the patient properly; and

(b) the Trust's convener failed to make clear whether she had taken appropriate clinical advice on the clinical aspects of Mr B's complaint from a person not associated with the complaint.

Investigation

3. The statement of complaint for the investigation was issued on 3 September 2001. Comments were obtained from CADOC and the Trust and relevant documents including clinical records were examined. Evidence was taken from Mr B, his daughter Dr B, the GP and a receptionist. Two professional assessors were appointed to advise on the clinical issues in this case and their report is reproduced in its entirety in paragraph 14 below. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked.

Complaint (a) The GP's assessment of the patient

Evidence of Mr B and Dr B

4. In correspondence to the Ombudsman and when interviewed **Mr B and Dr B** said that failures in the out of hours service procedures meant that Mrs B did not urgently receive medical attention. In their view, this lack of action resulted in her death by cardiac failure.

5. Mr B said that his wife suffered from dementia and needed one to one care which he provided. On 6 April they went for a short walk in the morning. In the afternoon he took her for a run in the car. At about 11.20pm she complained of feeling tired which was unusual and, in retrospect, was the first indication that she was not well. She was in bed by about 11.40pm. A little later Mrs B was sitting up in bed complaining of feeling unwell and breathless. She suffered from fluid retention and was sometimes breathless although at that time she was not visibly breathless and, as far as he could determine, she was not in pain. However, Mr B knew he had to do something. He consulted a leaflet from their local GP practice which gave an out-of-hours number emphasising that the number should only be dialled in an emergency. Believing his wife needed emergency assistance he telephoned the number at around 12.30am. A receptionist answered and asked him what was wrong with Mrs B. He tried to emphasise that he was an elderly man alone with his wife in her seventies and he told the receptionist that Mrs B suffered from dementia to indicate that she could not communicate well. The receptionist then asked a rapid series of questions not allowing Mr B time to think through the answers. Mr B tried to respond by giving the information he had always been asked for when he contacted any medical place about his wife – her

medication. He told the receptionist that Mrs B was on Adizem (for treatment of hypertension and angina), Captopril (for hypertension) and Frusemide (a diuretic) knowing that this would convey information about her condition. Mr B did not know at the time that this information was not recorded by the receptionist. The receptionist told him the doctor would telephone him. Mr B expected contact from the doctor in about ten minutes.

6. Mrs B was still sitting up and saying she did not feel well. About five to ten minutes before the doctor telephoned, she began 'shaking about' - her arms were moving and she was wriggling about the bed. Mr B could not say whether the movement was involuntary or whether Mrs B was moving about to try to get more comfortable. The GP telephoned at about 1.00am. He did not ask any diagnostic questions. He only seemed interested in getting Mr B to bring his wife to the CADOC base. Mr B had not wanted to get his wife out of bed and he had not wanted to drive at that time of morning. He told the doctor that Mrs B was not very mobile. He felt it was then up to the doctor to decide what action should be taken. The GP asked him to bring Mrs B to the base. Having described how she was and given their age and still been asked to take her to the base, Mr B felt that there was no possibility that the doctor would visit them at home. He therefore agreed to take his wife to the base. As he guided her down the stairs she became unable to support herself. He realised that he had done the wrong thing by taking the GP's advice and moving her but he was unable to lift her back up the stairs. It had not crossed his mind to dial 999 because he believed his wife would receive emergency attention from the out-of-hours service. He felt by then that it was too late to do anything other than continue with the doctor's advice and take his wife to the base as quickly as possible. Near the bottom of the stair she collapsed completely. Mr B struggled with her to the front door and then went for help. A neighbour lifted her into the car. Mr B drove to the CADOC base at Monklands Hospital about three miles away. During the journey Mrs B did not move. On arrival she was taken into hospital. Mrs B's daughter was contacted and she arrived about 15 minutes later. Mr B and his daughter were told that Mrs B's heart had been restarted and she was being ventilated. A cardiologist later told them that it did not look as if she would start breathing and that it was up to them to decide whether to switch off the ventilator. It was very difficult for them. The cardiologist could not say for

sure that she would not start breathing by herself and so they asked for the ventilator to be kept on for a little longer. Mrs B died on 8 April.

CADOC's records

7. A transcript of the telephone conversation between Mr B and the receptionist is attached to this report at appendix A and a transcript of the telephone conversation between the GP and Mr B is at appendix B. CADOC's written records include:

> '7 Apr 2000 00:36 Reported condition: dyspnoea [difficulty of breathing] h/o dementia.' [Entered by the receptionist]
>
> '[Discussed with] husband 1.00am – happy to come to base.' [Written by the GP]

Evidence of the GP

8. In his written response to the Ombudsman's statement of complaint **the GP** included:

> 'The receptionist started taking the patient's first contact call at 00.36. By the time I was informed of the call, it would have been at least three to four minutes later, given that the details had to be entered on the computer, printed out on paper and then picked up by me to be read. I read the information of "dyspnoea h/o dementia" but did not immediately return the telephone call because I was continuously examining patients from that time until 1.00am. Two of these patients required hospital admission for heart failure and acute urinary retention and the third was a distressed child in pain with his distraught mother.
>
> '... My interpretation, at the time, was that [Mr B] was prepared to bring his wife to the centre to be examined.
>
> 'When I contacted Mr B at 01.00 and enquired if the patient could come to base, I did so because I wanted to assess the patient, as soon as possible, by questioning and examination. I had not made a firm diagnosis. My view was that Mrs B needed to be seen and examined and, at the time, I was not under the impression that this

was an urgent or emergency situation. I considered that the conversation between myself and [Mr B] was relaxed and totally non-confrontational and I was reassured by the tone of our exchange.

'I feel that it is extremely important to note that the patient's condition severely deteriorated after our conversation. [Mr B] informed me at a meeting … that she was "breathless but walking about" when I telephoned and that she, in fact, collapsed after my call.

'I have considered this situation carefully … and have reviewed what I could possibly have changed in terms of both my time prioritisation and my questioning of patients. I have made the following changes:

'I now try to answer all my telephone messages as soon as possible whether the call appears serious or insignificant. There was a delay of about twenty minutes in my return call to [Mr B]. I have now managed to reduce this to about ten minutes. I still tend to complete my examination of a patient at CADOC whilst calls are coming in, unless of course they appear to be emergencies;

'My questioning of patients is more structured now. I routinely ask about: the presenting complaint and to expand on pertinent points raised; previous major illnesses; [and] medication of the patient. I accept I could have asked these questions of [Mr B]. However, both ischaemic heart disease and the prescribed medication for [Mrs B] are very common to this age group. Even if I had elicited these points I genuinely believe that my actions would have been the same.

'I do now reinforce to patients that if there is any deterioration in a patient's condition after my telephone call, the patient or carer should telephone me again for further advice. I have assumed in the past that patients would do this, but I now stress the point.

'… The specific issues raised by [Mr B] require comment:

'When I spoke to him on the telephone I asked several questions – as can be seen on the transcript [appendix B]. I asked about symptoms,

their duration, [Mrs B's] mobility, whether or not she could be brought to the centre and if [Mr B] was "okay" with this. I am sorry if [Mr B] felt that I "urged" him to bring his wife in. I did not realise that he felt pressurised in this way.

'Point 2(a) states that I did not put myself in a position to assess the patient properly. I did have information from the first telephone call and from [Mr B's] replies during my conversation with him. My decision was that [Mrs B] needed to be seen. I then had to prioritise whether I should visit or see the patient at the Centre. Based on my conversation with her husband, there was no indication of immediacy or that coming to the Centre was not possible. Usually when there is an urgent situation, patients make this clearly known. My understanding was that [Mrs B] was, in fact, in generally good condition (though needing to see a doctor) but that she suddenly and significantly deteriorated after I spoke to [Mr B].

'I do regret the pain and suffering that the family experienced and I have tried to assist them, so far as I am able with their complaints …'.

9. At interview the GP said that, at that time, only one doctor was on duty after midnight. He therefore had to deal with the patients calling at the base and the telephone calls. He expected receptionists to obtain the correct details of the caller to enable him to call back and a note of the basic presenting problem. He was satisfied with the information obtained by the receptionist in this case. He was with a patient when Mr B telephoned. He could not remember what the receptionist told him about the call. He decided that the waiting patients appeared more urgent and therefore he decided to see them before calling Mr B back. Having spoken to Mr B he decided he wanted to assess Mrs B properly by seeing her. He could have asked more questions about the presenting complaint, information about previous major illnesses and about medication the patient was taking, as he does now, but if he had done so in this case, he did not believe it would have altered his decision to ask Mr B if he could bring his wife to the base. When deciding whether a home visit is necessary he does not consider age as a deciding factor. The decision is based on the health of the patient. However, if Mr B had said that he was

not willing to bring Mrs B to the base or he felt she was not able to come then he would have arranged a home visit or an ambulance.

Evidence of the receptionist

10. **The receptionist** said that CADOC receptionists were expected to obtain callers' names and contact details and find out what the problem was then pass the request straight to a doctor in specific cases. If the call involved someone asking for advice or a prescription only then the information sheet was placed in a box for the doctor to deal with when he had time. If the doctor was with a patient she would not interrupt unless it was an emergency, such as chest pains, when she would order an ambulance then inform the doctor. She was not sure whether there were written protocols for receptionists in place at the time when Mr B called. If there were they related more to how to recognise an emergency rather than providing questions which should be asked in certain circumstances. Since the complaint had been made, protocols (which I and the professional assessors have seen) were issued and receptionists are expected to ask more questions than before which are tailored to specific complaints.

11. The receptionist said that most callers could give an extensive list of medications and it was not always meaningful to her. Also questions about medication were normally asked by the doctor when the doctor telephoned or saw the patient. Mr B had said his wife took Frusemide which indicated to her that Mrs B had fluid on the lungs and possibly a heart condition. She usually asked callers if they were able to come to the base, however, she did not ask Mr B because she felt that she had obtained sufficient detail to know that she would have to get the GP to call Mr B back. She told the GP that Mr B was very concerned about his wife thereby indicating that there was a degree of urgency and asked him to call Mr B. She could not be sure that she told the GP that Mrs B took Frusemide but would be surprised if she had not. The GP looked at the sheet then went to see another patient.

CADOC's response to the complaint

12. In a letter to Mr B and Dr B during the local investigation of the complaint **CADOC's Director** included:

> '... the CADOC receptionist answered the call as per her training. She obtained details regarding the patient's presenting complaint. I

accept that she hurried [Mr B] along a little, and I am very sorry about this, but most of the pertinent details were obtained. I also accept that more details should have been transposed on to the CADOC sheet for [the GP] to act upon. However, it is my understanding that the receptionist in question did convey more information to [the GP], although this was done so verbally. Receptionists have since been reminded to enter all relevant details on to the sheet in order to help the doctor decide on the best course of action.

'… [to distinguish real emergencies from routine calls] receptionists are trained to ask appropriate questions, and also, to a degree to use their common sense. Receptionists are trained to alert the doctor if a call sounds serious, e.g. chest pain, severe breathlessness, convulsion in a child. However, their responsibility is to seek advice from the doctor in any situation of doubt, and where any sense of urgency is imparted. In light of this unfortunate case receptionists have been alerted to ask more searching questions and, as before, we have reinforced that they must refer to the doctor if they are in any doubt.'

13. In his official response to the Ombudsman's statement of complaint, CADOC's Director included:

'There is perhaps one vital point I wish to emphasise. Mr B was asked by [the GP] quite clearly on the phone if he could bring his wife up to the base. He offered little resistance to that suggestion. I have no doubt in my own mind that if he had said that transporting his wife to the base was too difficult or in some way unreasonable, then [the GP] would have had no hesitation in either visiting the house, or in obtaining further details to ascertain if an immediate ambulance was necessary. In fact the sequence of events was such that [Mrs B's] condition deteriorated after the initial conversation … This later deterioration, if communicated to [the GP], would of course have changed his management of the case completely.

'… Patients are only visited if their condition renders them unable to attend (eg terminally ill, or nursing home patients), or if transporting them is likely to worsen their condition. Even if further details were

obtained from [Mr B] about his wife's condition it would still have been reasonable to ask them to attend the base, as it is my opinion that there would have been little to suggest that her condition would deteriorate merely by the fact of getting to CADOC base, a distance of about 3 miles.'

Report of the Ombudsman's professional assessors

14. I now set out the assessors' report:

Report by the Professional Assessors to the Scottish Public Services Ombudsman of the clinical judgments involved in the complaint made by Mr B

Matters considered

i) We have been asked to advise on whether the GP obtained sufficient information from Mr B to put himself in a position to assess the patient properly.

Basis of report

ii) We have reviewed all relevant documents, listened to a tape recording of the relevant telephone conversations and one of us attended (with the Ombudsman's investigating officer) interviews with Mr B and his daughter and the GP.

iii) The first point at issue is whether the GP's prioritisation of the return telephone call to Mr B was reasonable. While Mr B was clearly concerned about his wife he did comment at interview that just prior to calling CADOC Mrs B was not visibly breathless and as far as he could determine she was not in pain. In view of this and given the reported nature of the other patients the GP was dealing with at the time an approximate 25 minute delay in returning the call does not seem unreasonable. In general terms good quality information gathering and protocols can help with prioritisation and CADOC have to a large extent addressed this issue with their new protocols.

iv) *The next point at issue is whether the GP obtained enough clinical information to inform the decision regarding where Mrs B should be seen and if not at home the most appropriate transport arrangements. The GP himself freely admits in some of the documents that he could have asked more clinical questions and indeed he has changed his practice to reflect this. Unfortunately we feel that the GP did not consider the possibility that Mrs B's breathlessness might be due to cardiac failure and had he done so we feel that he would not have requested that she be brought to the CADOC base. It is however clear that he realised that she should be seen quite soon and he was reassured by the manner of his conversation with Mr B. It is not true that the GP 'urged' or 'insisted' that Mrs B be brought to the base and indeed he gave Mr B at least four opportunities to disagree with this plan of action. It is likely that the GP's actions were influenced by the fact that he was extremely busy and he was trying to make what he considered to be the most efficient arrangements for all the parties concerned. Unfortunately we do however think, on balance, that other clinical information should have been obtained and therefore the GP's clinical actions fell below a standard which the patient could have reasonably expected in the circumstances.*

v) *We would like to make the general point that age as such is not a relevant factor in deciding whether a patient is fit to travel to be seen and that decisions regarding where and when a patient is seen should be based almost entirely on their clinical condition. Mrs B was well enough earlier in the day in question to go for a short walk outside and also to take a trip in the car. It is certainly possible that when she first became unwell that she would have been fit to travel to the CADOC base and that the GP would have made the same decision as he made on the night in question. Unfortunately, however, the GP did not obtain enough clinical information to enable him to reach a balanced decision on where best Mrs B should have been seen and what the most appropriate transport arrangements should have been. We note that once again the new CADOC protocols largely address this issue.*

Findings (a)

15. Mr and Dr B said that failures in the out of hours procedures meant that Mrs B did not urgently receive medical attention which resulted in her death by cardiac failure. Among their concerns were that not all the information given by Mr B to the receptionist was passed to the GP; the time taken by the GP to return the call; the GP's failure to ask any diagnostic questions; and his decision to ask Mr B to bring his wife to the CADOC base. The GP was satisfied with the information obtained by the receptionist. He had three patients at the base and Mr B's telephone call to prioritise which he did as he considered appropriate in the circumstances. He telephoned Mr B about 25 minutes after Mr B's call was received at the base. The GP decided that he needed to assess the patient but was not under the impression that this was an urgent or emergency situation. He accepted that he could have obtained more information but thought it unlikely that would have altered his decision and there was no indication given by Mr B that attending the CADOC base was not possible. The GP and CADOC's Director emphasise that Mrs B's condition deteriorated significantly after the GP's call to Mr B.

16. The question I have to address is whether the GP obtained sufficient information to put himself in a position to assess Mrs B properly. In reaching my findings I have been guided by the advice of the Ombudsman's professional assessors. The assessors are of the view that given Mr B's description of his wife's symptoms prior to calling CADOC and the reported nature of the other patients, an approximate 25 minute delay in returning the call does not seem unreasonable. I accept that advice. However, the GP did not know the extent of Mrs B's breathlessness or whether she was in pain. He only knew what had been recorded by the receptionist and possibly that Mrs B was on Frusemide. It therefore seems to me that the GP was not in a position to prioritise effectively. In considering whether the GP obtained enough clinical information, the assessors feel that the GP did not consider the possibility that Mrs B's breathlessness might be due to cardiac failure. On balance they believe other clinical information should have been obtained and therefore the GP's clinical actions fell below a standard which the patient could reasonably expect. They consider that it is possible that when Mrs B first became unwell that she would have been fit to travel to the CADOC base. They conclude that the GP did not obtain enough clinical information to enable him to reach a balanced decision on where best Mrs B should have been seen and what the most appropriate

transport arrangements should have been. I accept that advice. Therefore I uphold the complaint.

17. The assessors note that good quality information gathering and protocols can help with prioritisation and CADOC have to a large extent addressed this issue with their new protocols. I accept that advice. I also note that the GP has since cut the time taken to call patients back and changed his practice as outlined in paragraph 8 to obtain more information from patients. I consider that CADOC and the GP have taken appropriate remedial action.

Complaint (b) Whether appropriate advice was taken by the convener

National guidance

18. Revised guidance on the NHS complaints procedure issued in May 1999 by the then Scottish Office includes:

> '2.9 In reaching a decision, the convener must … take appropriate clinical advice where the complaint relates in whole or part to action taken in consequence of the exercise of clinical judgement …
>
> '2.12 Clinical advice should relate to whether the response already made to the clinical aspects of the complaint at local resolution has been thorough, correct and fair …'.

Evidence of the Trust

19. In his formal response to the Ombudsman's statement of complaint the Trust's **Chief Executive** included:

> '… I acknowledge that the complaint does have a significant clinical component and [the Convener] did not make it clear whether she had sought clinical advice from an independent professional person. I believe both [the Convener] and the Lay Chair after considerable consideration, believed that the extensive attempts from both sides to reach Local Resolution, reduced the need to make it clear that appropriate clinical advice had been taken.
>
> ' … I … have been assured that independent professional advice will be sought for any complaints that have a clinical judgement focus.'

20. In her formal response to the Ombudsman's statement of complaint **the Convener** included:

> '... I can confirm that the Lay Panel Chair and I on the basis of [Mr and Dr B's] letter to me of 14 March 2001 which set out the issues they wished reviewed fully considered whether clinical advice at this stage was necessary to address the issues raised particularly their request for "Clear unequivocal written acknowledgement of mistakes and flaws in procedure including ... acknowledgement in writing from [the GP] of his failure to meet his professional responsibility to adequately ascertain sufficient information from [Mr B] before deciding to ask him to take his wife to the Monklands Hospital ...".
>
> 'We discussed if clinical advice could further clarify any aspect of [the GPs] clinical judgement to enable us to reach the appropriate decision on this issue and took the conscious decision that it was not necessary to seek clinical advice either from a person not associated with this complaint or indeed from any other person as from the information we had studied [the GP] had without reservation verbally apologised to [Mr and Dr B] for the clinical judgement he had made on the evening of [Mrs B's] death and had revised his protocols for dealing with such telephone calls. We also understood this apology had been accepted by [Mr and Dr B]. Therefore in our opinion consideration on this issue did not require clinical advice.
>
> 'Also as far as the other issues raised were concerned we decided after detailed discussion including reference to the information pertaining to the Local Resolution Process that clinical advice was unnecessary at this stage.
>
> 'If independent clinical advice had been sought I would have made reference to this in my correspondence with [Mr and Dr B] ...'.

Findings (b)

21. The Chief Executive acknowledges that the complaint which Mr B put

to the Convener contained a significant clinical element. Despite that the Convener decided, for the reasons set out in paragraph 20, that it was not necessary to seek clinical advice. However, the guidance (paragraph 18) is clear on this issue. I note with approval, that in future the Convener will seek independent clinical advice. I uphold this complaint.

Conclusions

22. I have set out my findings in paragraphs 15 to 17 and 21. CADOC and the Trust have asked me to convey – as I do through my report – their apologies to Mr B and Dr B for the shortcomings I have identified.

Gillian Stewart
Senior Investigating Officer
duly authorised in accordance with
paragraph 11 of Schedule 1 to the
Scottish Public Services
Ombudsman Act 2002

November 2002

Appendix A

Transcript of the Mr B's telephone call to CADOC

Mr B My name is[gives full name].

Receptionist Uh huh.

Mr B My wife and I are over 75. My wife's having difficulty breathing.

Receptionist What's your phone number?

Mr B [Gives telephone number].

Receptionist What's your wife's first name?

Mr B [Give's wife's first name].

Receptionist A?

Mr B Right …[gives wife's date of birth].

Receptionist Hold on a wee minute. What's your address?

Mr B [Gives address].

SPACE IN TAPE

Receptionist And her date of birth?

Mr B [Repeats wife's date of birth].

Receptionist And her own doctor?

Mr B [another GP]

Receptionist Right. And has she had any problems like this before?

Mr B Well of course. She has dementia … you know she's had …

Receptionist What about … I mean has she got any chest problems or heart problems or anything?

Mr B She takes Adizem eh Frusemide, Captopril.

Receptionist Right. Has she ever, right … right, has she been in hospital before with her breathing?

Mr B Eh … not really … no.

Receptionist And is this worse than you've ever seen her?

Mr B Well I'm really disturbed about her, you know, I'm …

Receptionist Right, okay. Doctor'll give you a ring back then, okay?

Mr B Okay, Thanks.

Receptionist Right you are. Bye

Mr B Bye.

Appendix B

Transcript of the GP's Telephone Call to Mr B

Mr B Hello.

The GP Hello. It's [the GP] here following up about [Mrs B].

Mr B That's correct.

The GP Right. Now she's breathless?

Mr B She's eh, like, eh … she's hard of breathing and she's shivering, you know. Shaking a bit.

The GP How long has she been like that for?

Mr B Well, it started about 11 o'clock, you know, and eh, I thought … she's never got any great difficulty breathing.

The GP Okay. Is she mobile?

Mr B Eh, not very, eh … not, not much, you know.

The GP Right, have you anybody able to bring you down to the Emergency Centre here?

Mr B Eh … where is that sir?

The GP Right, if you just come down to Casualty, there's a door to the left that says GP Treatment Centre.

Mr B Uh huh.

The GP If someone brings her down there I'll see her as soon as she arrives or within one or two minutes of her arrival.

Mr B Right.

The GP Would that be okay?

Mr B Okay.

The GP Right. So just come to Casualty. There's a door to the left of Casualty; GP Treatment Centre and you come in through that door.

Mr B Right.

The GP Okay.

The GP See you then. Bye bye.

Mr B Bye.