Scottish Parliament Region: Highlands and Islands

Case 200600182: A Medical Practice, Western Isles NHS Board

Summary of Investigation

Category

Health: Health/FHS; GP & GP Practice/Clinical Treatment/Diagnosis

Overview

On behalf of Mr and Mrs A (the aggrieved), a solicitor (Mr C) complained that their son (Mr B) died as a result of inadequate medical treatment.

Complaints and conclusions

The complaints which have been investigated are that:

(a) the GP 1 failed to act in a timely manner (*not upheld*); and

(b) Mr B received inadequate medical treatment which led to his death (*not upheld*).

Redress and recommendation

The Ombudsman has no recommendations to make.

Main Investigation Report

Introduction

1. On 10 November 2005, the Ombudsman received a complaint from a solicitor, Mr C, on behalf of his clients, Mr and Mrs A. Mr and Mrs A's son, Mr B, died on 18 June 2003 at the age of 19 and it was their view that the GP (GP1)'s actions (or inactions) (GP1) contributed to his death. They said that, if communication had been better and if further tests had been carried out on Mr B, the outcome for him may have been different. They maintained that, as his ECG was revealed to be abnormal, more should have been done, and faster.

2. The complaints from Mr C which I have investigated are that:

(a) the GP 1 failed to act in a timely manner; and

(b) Mr B received inadequate medical treatment which led to his death.

Investigation

3. The investigation of this complaint involved obtaining and reading all the relevant documentation, including Mr B's medical records. I have also had sight of correspondence between Mr C and the Western Isles NHS Board (the Board) and GP 1; between a charity concerned with heart disease (the Charity) and GP 1; and between GP 1 and the Board. On 25 May 2006, GP 1 was notified of my intention to investigate and given the opportunity to comment on the matter. Independent medical advice from the medical adviser to the Ombudsman (the Adviser) was also sought on the GP 1's actions and the treatment offered to Mr B.

4. While I have not included in this report every detail investigated, I am satisfied that no matter of significance has been overlooked. Mr C and GP 1 were given an opportunity to comment on a draft of this report.

(a) The GP failed to act in a timely manner

5. During the Spring and Summer of 2002, Mr B participated in a medical project organised by the Charity to identify undetected cardiac conditions in young people. He was identified as a case for follow-up and was invited by the Charity for further tests on 9 July 2002. Mr B, who was a merchant seaman, did not attend and, on 10 October 2002, the Charity asked for his GP's help to get him an ECG and an ultrasound scan of the heart. GP 1 referred Mr B to the Western Isles Hospital (the

Hospital) on 25 November 2002, asking for an appointment at 'your earliest convenience'. GP 1 then wrote to the Hospital again, enclosing a copy of a letter from the Charity, on 10 December 2002.

6. I have seen the letter from the Charity addressed to GP 1, dated 10 October 2002. It is date stamped as being received on 5 November 2002. The letter advised that Mr B was one of three young people who had been unable to attend for follow-up tests and, as his previous ECG was classed as abnormal, it was the Charity's view that he should receive a further ECG and an ultrasound scan of the heart which would be reviewable by the Charity's consultant cardiologist. The Charity was looking for the GP's help and support to provide a referral to hospital but it acknowledged the difficulties associated with this because of Mr B's employment as a merchant seaman.

7. In his comments to me of 22 June 2006, GP 1 pointed out that, prior to his written referral to the Hospital, he made efforts to contact Mr B by telephone to explain to him that the Charity had requested a referral and that an appointment would be sent to him. He said he had done this to try to avoid the situation of an appointment arriving without explanation. Similarly, he said, efforts had been made to establish when Mr B would be back on shore but this had been 'in vain' and he was unable to forewarn Mr B about the appointment. In commenting on a draft of this report GP 1 said that he did not see Mr B at all throughout the period covered by this complaint.

(*a) Conclusion*

8. Mr C believes that GP 1 was tardy in acting on the letter from the Charity dated 10 October 2002. He believes that this could have affected Mr B's prognosis. However, GP 1 did not receive the Charity's letter until 5 November 2002. Thereafter, he took steps to try (albeit unsuccessfully) to contact Mr B to explain what was going on. He then requested a referral within three weeks of him receiving the letter (see paragraph 5).

9. As part of my investigation I sought independent medical advice and it has been confirmed to me that, in all the circumstances, the timescales involved were reasonable and that the Adviser 'would not feel the problem of an abnormal ECG in an apparently fit young man warranted any faster action'. The Adviser went on to

point out that, after Mr B was seen by the consultant physician at the Hospital on 8 January 2003, an annual follow-up was advised. He said that, given this, it was impossible to criticise GP 1. Accordingly, I do not uphold the complaint.

b) Mr B received inadequate medical treatment which led to his death

10. After being requested by GP 1, the Hospital made arrangements for Mr B to receive an ECG and echocardiogram on 8 January 2003 and the results were sent to the Charity on 21 January 2003. GP 1 received a copy of this letter (but not until 6 February 2003): it said that Mr B's examination had shown no significant abnormality and that the Hospital consultant physician hoped to 'follow him up yearly for echo review locally'.

11. The next occasions when a GP was involved (not the GP the subject of this complaint, but GP 2, his partner) were on 10 and 15 May 2003, when Mr B came to the surgery complaining of breathlessness. Mr B had a history of asthma and he was treated accordingly. With hindsight, the independent adviser said that these symptoms may well have represented the start of his heart failure but it is not possible to be sure. Nevertheless, he Adviser confirmed that, in the circumstances, the treatment given to Mr B was reasonable.

12. On 20 May 2003, Mr B went back to the surgery and was seen by GP 2. The notes taken at the time said that, while he was a bit breathless, he was much improved. They record that Mr B said he wanted to go back to sea. However, later in the day Mrs A telephoned the GP practice, saying that Mr B was ill and that he had not been describing all his symptoms. As these sounded much more severe than he had been led to believe, GP 2, who had already seen Mr B, decided that he had to see him again, which he did. He recorded that, while Mr B's chest was clear, he was breathless and, because of all the things he had omitted to reveal (which appeared to be true) and because he had had an abnormal ECG, Mr B was immediately admitted to the Hospital later that evening. He was transferred to Glasgow Royal Infirmary the next day where, sadly, he later died (on 18 June 2003) from septicaemia associated with the consequences of dilated (viral) cardiomyopathy.

(b) Conclusion

13. Mr C alleges that the treatment Mr B was given by his GP was inadequate and that this contributed to his death. However, the Adviser does not support this view. He said that, as the Charity was running the programme, he would not have expected any action by GP 1 prior to the onward referral (as described in paragraph 5). On the next occasion when Mr B presented in the surgery, on 10 May 2003, he was treated by GP 2 according to his symptoms and, while he Adviser said that with hindsight these incidents may have indicated a more serious episode, it is not possible to be sure. In the circumstances, he considered the treatment to be reasonable.

14. This is a sad case relating to the death of a young man. The tragic irony is that he died having been screened for heart disease as part of a process to prevent such an event. I sympathise fully with Mr and Mrs A's loss of their son. Taking into account the evidence including the independent medical advice I have received, I do not consider that GP 1's action contributed to the death of Mr B. I do not uphold this complaint.

28 November 2006

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Mr and Mrs A	The aggrieved
Mr B	Mr and Mrs A's son
GP 1	The GP who is the subject of the complaint
GP 2	GP 1's partner
The Hospital	The Western Isles Hospital
The Board	The Western Isles NHS Board
The Charity	A charity to identify undetected cardiac conditions in young people
The Adviser	The medical adviser to the Ombudsman