Scottish Parliament Region: Lothian

Case 200601828: A Medical Practice, Lothian NHS Board

Summary of Investigation

Category
Health: GP

Overview
The complainant (Mrs C) raised a concern that her late father's GP (GP 1) failed to provide reasonable care and treatment to her father (Mr A) in the two days immediately prior to his unexpected death in January 2006.

Specific complaint and conclusion
The complaint which has been investigated is that GP 1 failed to provide reasonable care and treatment to Mr A (*not upheld*)

Redress and recommendation
The Ombudsman has no recommendations to make.

Main Investigation Report

Introduction

1. On 19 September 2006 the Ombudsman's office received a complaint from Mrs C about the lack of care and treatment provide to her late father (Mr A) by a GP (GP 1) at the medical practice where he was registered (the Practice) on the 24 January 2006 (and a failure to provide follow up on 25 January 2006). Mrs C believed that this failure led directly to her father's death on 26 January 2006. Mrs C complained to the GP practice on 27 January 2006 and raised the matter with the General Medical Council (GMC) on 21 March 2006 but was not satisfied with the responses received and complained to this office.

2. The complaint from Mrs C which I have investigated is that GP 1 failed to provide reasonable care and treatment to Mr A.

Investigation

3. Investigation of this complaint involved obtaining and reviewing Mr A's relevant medical records and the Practice complaints file. I have also reviewed correspondence and reports submitted by Mrs C and sought the views of two GP Advisers (Adviser 1 and Adviser 2) to the Ombudsman's office. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C and the Practice were given an opportunity to comment on a draft of this report.

Complaint: GP 1 failed to provide reasonable care and treatment to Mr A

4. On 24 January 2006 the Practice received a call from one of Mr A's daughters (Mrs D) stating that Mr A was shaky and confused and requesting a home visit for him. GP 1 visited later that day after evening surgery. GP 1 made a working diagnosis of viral infection (she alter noted that a flu virus was prevalent in the community at the time) and advised Mr A to increase his fluid intake and take paracetamol if needed. GP 1 later called Mrs D and repeated this advice. The following evening Mrs C called her father and was concerned when he dropped the telephone and she lost contact with him. Mrs C and Mrs D drove to Mr A's house but could not gain access and called the paramedics who broke down the door. Mr A was found in a sate of collapse and was admitted to hospital by emergency ambulance at 22:30. He was in acute renal failure and treated with antibiotics and IV fluids. He suffered a cardiac arrest and died in the early hours of 26 January 2006. The primary

causes of death were listed as multiple organ failure, spies and urinary tract infection.

5. Mrs C complained to GP 1 at a meeting on 27 January 2006 and received a further written response from the Practice on 2 March 2006. Further details of her visit to Mr A were provided by GP 1.

6. The GP record for 24 January 2005 notes:

> 'Call from daughter in Glasgow / complaining of being shaky and confused. Orientated in time place and person.
> Complaining of being slightly shivery. No other symptoms
> On examination – no abnormality detected. Abdomen soft, apyrexial, slightly dry.'

7. Mrs C complained that GP 1 had failed to take appropriate note of all the symptoms and consequently failed to perform appropriate tests. In particular Mrs C noted that GP 1 had used her hand rather than a thermometer to take Mr A's temperature; had not tested his blood although he was diabetic; had not tested his urine despite a history of urinary tract problems and did not try to discover the cause of his dehydration. Mrs C noted that her father had previously been successfully treated for a urinary tract infection when he been immediately prescribed (and received) antibiotics. In response to the draft of this report Mrs C further noted it was her view that the doctor visited for ten minutes after 18.00. She also told me that a neighbour (Mrs G) had visited Mr A that afternoon because he had not opened his curtains by mid-afternoon and that that was unusual and the neighbour had found Mr A to be very shaky and rather confused.

8. Adviser 1 told me that a thermometer is the most accurate method of determining a patient's temperature but that it is reasonable and acceptable to feel the forehead with the fingers as a general indication. Adviser 1 also stated it was reasonable for GP 1 not to test blood or urine as her physical examination and assessment of Mr A's consciousness did not reveal any need for this. Adviser 1 did not consider that the degree of dehydration recorded by GP 1 would have warranted further examination. Adviser 1 noted that Mr A's temperature and diabetic state were both later recorded as normal (for a diabetic patient) on his admission to hospital.

9. Following sight of Adviser 1's views Mrs C told me that she did not feel that GP 1's record of her father's condition that evening was accurate and did not portray his true level of debility. Mrs C provided me with a statement from Mrs G who had prompted the request for a GP visit on the 24 January 2006 because of her concerns about him when she saw him that day.

10. I asked Adviser 2 to review the file again in light of Mrs G's further evidence. Adviser 2 supported the views of Adviser 1 that GP 1's actions were reasonable in the circumstances and told me that very sadly a patient's condition can sometimes deteriorate extremely rapidly and it is not always possible for a GP to foresee such deterioration. Adviser 2 considered that this was unfortunately what had occurred here.

11. Mrs C was also concerned that GP 1 had not made arrangements to revisit Mr A on 25 January 2006 despite telling Mr A that she would. The only reason his family had not arranged to visit him earlier on that day was because they believed that someone from the Practice would be visiting.

12. GP 1 stated that she had advised Mr A to contact the Practice if he needed to but had made no arrangement to visit. GP 1 stated that in hindsight she would perhaps have ensured that Mr A would be reviewed the next day or was to be visited by his family.

13. Adviser 1 told me that it is not practical to arrange follow-up for every patient and especially one who has been found not to be confused and is thought to have a self-limiting illness.

Conclusion

14. Based on the medical advice I have seen I conclude that the care and treatment provided to Mr A by GP 1 was of the standard expected of a reasonable professional and I do not uphold this complaint.

22 August 2007

Annex 1

Explanation of abbreviations used

GMC	General Medical Council
Mrs C	The Complainant (Mr A's daughter)
Mr A	The Aggrieved
GP 1	The GP from the GP Practice who attended Mr A on 24 January 2006
The Practice	Mr A's GP Practice
Adviser 1	A GP adviser to the Ombudsman
Adviser 2	A GP adviser to the Ombudsman
Mrs D	Mr A's daughter
Mrs G	Mr A's neighbour