Scottish Parliament Region: South of Scotland

Case 200502012: Ayrshire and Arran NHS Board

Summary of Investigation

Category

Health: GP out-of-hours service

Overview

The complainant (Mrs C) raised a number of serious concerns about the examination given to her son by the local GP out-of-hours service prior to his admission to hospital and subsequent death from meningococcal septicaemia.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the out-of-hours GP failed to carry out an appropriate examination and as a result failed to make a correct diagnosis *(not upheld)*; and

(b) Ayrshire and Arran NHS Board failed to carry out an appropriate investigation into the circumstances surrounding the examination *(not upheld).*

Redress and recommendations

The Ombudsman has no recommendations to make.

Main Investigation Report

Introduction

1. On 5 December 2005, the Scottish Public Services Ombudsman's office received a complaint from a woman (Mrs C) that the out-of-hours service GP (GP 1) who was on duty at the local GP out-of-hours service had failed to correctly diagnose meningococcal septicaemia in her son (Child A), despite symptoms which, she believed, should have warned GP 1 of this potential condition. Child A subsequently died early the next morning after being admitted to the local Accident and Emergency Department.

2. On 28 February 2005, Mrs C raised her concerns about the examination and diagnosis made by GP 1 with Ayrshire and Arran NHS Board (the Board). However, she remained unsatisfied with the Board's response to her complaint. As a result of this, she asked our office to investigate her concerns about GP 1's examination and diagnosis and what she believed to be the Board's failure to carry out a full and appropriate investigation into her concerns.

3. The complaints from Mrs C which I have investigated are that:

(a) GP 1 failed to carry out an appropriate examination and as a result failed to make a correct diagnosis; and

(b) the Board failed to carry out an appropriate investigation into the circumstances surrounding the examination.

Investigation

4. I have obtained the clinical records in respect of this case as well as the complaints files held by the Board. I have met with GP 1 to discuss the examination and subsequent complaint. I have also sought clinical advice from our independent clinical advisers. I have set out, for each of the headings of Mrs C's complaint, my findings of fact and conclusions.

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

6. The death of any child is a tragedy for their parents and family. In this case, the tragedy is made more difficult to understand by the very fast progression of the illness and the suddenness of the child's death. I appreciate

that this must have been a very difficult period for Mrs C and her family to both come to terms with and understand.

(a) GP 1 failed to carry out an appropriate examination and as a result failed to make a correct diagnosis

7. On the morning of 3 January 2005, Child A returned by train to Mrs C's parents' home, where they had been staying over Christmas. On arrival at home at around 13:30 he seemed tired, but normal. At around 17:00 Mrs C advised that she noticed that he had developed a fever and so she administered Calpol. At this point she states that he complained of a headache and stomach ache.

8. At around 21:00, Mrs C administered further Calpol as Child A's temperature had continued to rise during the course of the evening. Because he vomited this dose, and as Mrs C was not sure whether she should give him a further dose, she telephoned NHS24 for advice.

9. In her letter of complaint to the Board of 28 February 2005, Mrs C stated that she telephoned NHS24 for advice because she was not sure whether to administer further Calpol, but also because she was concerned as Child A was unable to walk and could not hold up his head. She wrote that she contacted NHS24 and discussed her concerns with the nurse adviser. Mrs C advised that the nurse adviser said to her that she did not want to cause alarm but that she had checked a list and thought it could be meningitis. Mrs C details in her letter that she was told not to panic as she could see a GP quickly. She was asked by the nurse adviser how quickly she could attend the GP out-of-hours service centre and an appointment was made for 21:30.

10. Mrs C wrapped Child A in a blanket and drove, with her husband and sister, to the out-of-hours service centre where she advised they arrived at 21:22. She then states that it was not until 21:55 that she was seen by GP 1.

11. Mrs C states that apart from checking Child A's ears, at Mrs C's insistence, GP 1 did not carry out any proper examination of Child A. She states that he did not undress Child A, try to communicate with him or check his head or stomach, despite Mrs C pointing out to GP 1 that she had never seen him in such a motionless state. Mrs C states that they were given a bottle of 'Nurofen' (ibuprofen) and advised to see their own GP in the morning. She also stated that when Child A's floppiness, cold extremities and confusion were brought to

the attention of GP 1 he suggested that this was simply the result of flu. Mrs C has suggested that she feels GP1 was very dismissive of her concerns. She has stated that when she questioned his diagnosis GP1 replied 'What do you feel like when you have flu Madam?' and also 'Who is the doctor here?' Mrs C said that GP 1 never made any attempt to talk to Child A at any stage of what she suggests was only a three or four minute examination.

12. Mrs C clearly states that the examination given by GP 1 to Child A was only cursory and fell far short of satisfactory.

13. In his response to Mrs C's complaint, the Chief Operating Executive (GP 2) wrote to her on 10 May 2005. In his letter, he advised that he understood that she arrived at around 21:25 and was seen by GP 1 immediately following the end of his previous consultation at 21:45.

14. He further advised that GP 1 has a standard set procedure for examining fevered children and that he had stated that he was satisfied that he had carried out this examination in the usual way. GP 2 goes on to advise that GP 1 recalled that whilst Child A lay across Mrs C's lap, he examined his abdomen, chest and skin surface. GP 1 states that he recalls that Child A wore loose fitting nightwear and that it was not necessary to strip him completely. Mrs C disagrees with this view and considers that Child A wore tight fitting nightwear and that GP1 did not carry out a full skin examination.

15. GP 2 advised that GP 1 stated that he examined Child A's head, neck and ears, nose and throat as he would with any child with a similar presentation. GP 1 also advised that his view was that whilst Child A was still, he was fully conscious, alert and cooperative. GP 1 also claims that he spoke to Mrs C and Child A throughout the course of the consultation and that the consultation was not rushed as he was not busy that particular night.

16. I have reviewed all the background information relating to this case including the records of the consultation and have sought advice from two independent clinical advisers. I, along with one of these advisers, have met with GP 1 to discuss his recollections of the consultation and the process he followed when undergoing the examination.

17. The records of the consultation are very brief. These are held within a computerised record which records details of who made the entry, the time and brief notes.

18. It is clear from the computer records that GP 1 entered the examination details only in part, during the consultation. The computer records do not start until after the consultation is well under way and record the prescription of ibuprofen syrup before the history and examination details are entered. Indeed, they are recorded as having been entered after the end of the consultation. When asked about this GP 1 advised that he had used written notes rather than the computer to record the information at the time. This was, in part, as the system was very new but was also for ease of reference.

19. He then typed up his findings after the consultation. This explains the order the information was entered on the computer and also the erroneous timings.

20. The information which details GP 1's examination of child A is given in these records as follows:

> Temp 39.1 ent nad chest clear. Abdo nad. No rash or meningism

21. This details Child A's temperature, that his ear, nose and throat were checked and showed no abnormalities, his chest was checked and was clear, his abdomen was checked with no abnormalities detected and that, on examination, there was no rash or meningism.

22. Mrs C has raised a number of issues about the examination carried out by GP 1. She feels that GP 1 failed to carry out any detailed examination. Her recollections of events are significantly different to that of GP 1. She states that he made a cursory examination of Child A stating that 'if it makes you happy I'll check his ears'. She has further questioned how GP1 could state that Child A's chest was clear as she states that he did not use a stethoscope. GP1 also recalled removing Child A's nappy to carry out his examination, Mrs C states that Child A was fully potty trained and did not wear a nappy, she has also provided a letter from his nursery school which supports this.

23. In addition, she questions GP 1's assertion that Child A was fully conscious, alert and cooperative. In a letter of 28 June 2005, Mrs C detailed that she considers that Child A was far from being fully conscious, alert and

cooperative. She suggests that had this been so he would have been playing with the toys in the department.

24. Mrs C also suggests that by this stage Child A had become very listless and was unable to lift his head and considers that the signs were evident 'for all to see'. She states that Child A was immobile, unable to walk, had his eyes closed throughout, and was completely silent except for moaning when GP 1 checked his abdomen. She also advises that GP1 did not speak to Child A at all because Child A was completely unresponsive.

25. She states that when contacting the NHS24 helpline the nurse adviser said to her that she did not want to worry her, but that she should go to the GP out-of-hours service as soon as possible as she suspected that this may be meningitis. In the subsequent complaints correspondence received on 5 December 2005 Mrs C details that she finds it hard to believe that Child A had not been referred to the Paediatric Assessment Unit given what she considers was the uncertainty over the diagnosis.

26. GP 1 was later asked, at our interview, for his recollections of the circumstances surrounding the examination. He recalls that the examination followed his standard procedure for a fevered child. He advised that Child A was wrapped in a blanket and dressed in pyjamas which allowed him to carry out his examination without fully removing all of Child A's clothes.

27. GP1 said that after examination he was satisfied that Child A was suffering from a childhood infection which produced 'flu like' symptoms. As a result of this he prescribed ibuprofen and sent the family home with instructions for them to contact the out-of-hours service if his condition deteriorated in any way.

28. GP 1 in his response to the complaint and during our meeting was very clear in his view that he had carried out a full examination of Child A as he would do with any fevered child. GP 1 states that he carried out his usual full examination which included noting that Child A was alert and fully conscious, he took his temperature, examined his ears, nose and throat, his colour was normal, he examined his chest and took his heart rate and pulse, and checked his abdomen.

29. GP 1 also stated that he checked Child A's full skin surface, and recalled removing his nappy. He explained that he thought he must, therefore, have

removed his pyjama trousers to do so. He also advised that as Child A's clothes were very loose fitting he was able to examine most of the skin surface without removing the rest of his clothes.

30. As part of the specific examination for signs of meningitis, GP 1 also states that he checked Child A's neck for neck stiffness and pain which could be a sign of a problem with the meningism, and also carried out a Kernig's test. This is a test where the leg is moved and straightened. If there is any pain when trying to straighten the leg then this could be a sign of meningitis. In this case, GP 1 advised that this test was carried out without any problems being identified.

31. On the computer records of the telephone call made to NHS24 a checklist is followed by the nurse adviser to assist in diagnosis and prioritising of cases. The listing leads the nurse adviser through a series of questions designed to identify or exclude certain conditions to try and provide as clear a picture of any condition as possible and to decide on the priority of the case.

32. In this case, the nurse adviser took Mrs C through a series of standard questions specifically designed to triage or provide an initial assessment for a fevered child.

33. Some of the questions relate to specific points raised by Mrs C in her complaint. The questions, with Mrs C's answers, include:

> Does the child have any of the following symptoms?
> Completely floppy without muscle tone
> Unresponsive to the care giver or cannot be aroused
> NO
>
> Does the child have a rash with purple spots or bleeding into the skin and do they remain when a glass is rolled over them?
> NO
>
> Does the child have any of the following symptoms?
> Intense headache
> Mental confusion or difficult to rouse
> NO
>
> Does the child have any of the following symptoms?

Sleepy or difficult to waken compared to usual
More floppy (Limp) than is normal for him/her
Responds less to what is going on around him/her
NO

Does the child have any of the following symptoms?
Has refused to drink their usual fluids during the last 8 – 12 hours
YES

34. The records go on to note the following advice recommended:
The symptoms described during this call suggest that the individual should contact the GP practice as soon as possible (at least within 4 hours). WORSENING: If symptoms persist, worsen, if any new symptoms develop, call us back or contact the GP practice when the surgery reopens.

35. The nurse adviser then went on to make an appointment at the out-of-hours service primary care treatment centre. An appointment time was requested for 'as soon as possible' but within four hours. This four hour timescale is a standard non-urgent appointment timescale and not an emergency one. As the out-of-hours service was not busy, an appointment was arranged for 21:40, a time some 20 minutes after the call to NHS24 ended.

36. The symptoms of meningitis and meningococcal septicaemia can progress very quickly indeed. The triage carried out by the nurse adviser was carried out approximately 30 to 45 minutes before the consultation with GP 1.

37. It is clear from the results of the nurse adviser's questions that at the time of the telephone call, Child A did not have some of the symptoms which Mrs C has suggested that Child A had when he saw GP 1. For example, Mrs C has suggested that Child A's head was floppy during the consultation and she has questioned GP 1's view that Child A was fully conscious, alert and cooperative.

38. The notes recorded by the nurse adviser detail that when Mrs C made the telephone call, Child A was not floppy and without muscle tone. Additionally, Mrs C appears to have answered 'no' to questions asking whether Child A was more floppy than normal, whether he was sleepy or more difficult to awaken than normal, responds less to what goes on around him or is unresponsive to the care giver or cannot be roused.

39. Mrs C disputes the accuracy of the NHS24 checklist, she has stated that 'the answers to the questions as documented in the transcript are inaccurate.' She also questions why she was referred to GP 1 at all if the checklist had truly reflected her responses to the NHS24 nurse.

(a) Conclusion

40. Mrs C has stated that the consultation was superficial and only lasted a couple of minutes. She further suggests that GP 1 only checked Child A's ears and then only after her asking him to do so. She states that any suspicion of meningitis or meningococcal septicaemia and GP 1 should have referred Child A to hospital for further tests.

41. GP 1 on the other hand advised that he carried out the usual range of tests he would normally carry out given the presentation of a fevered child. He states that the consultation was not rushed as the centre was not busy that day. He also advises that he could not have carried out his examination in the brief time Mrs C has suggested he spent reviewing Child A. The Ombudsman's clinical adviser has confirmed that if GP 1 carried out the full examination he has claimed then this would have been a comprehensive examination.

42. The evidence in this case consists of the statements of Mrs C and GP 1, as well as the written records of the consultation and of the telephone call to NHS24. The statements of Mrs C and GP 1 about the consultation contradict each other. The record of the telephone call with NHS24 indicates that at that time, Child A did not have clear symptoms of meningitis and the resulting appointment, although urgent, was not an emergency one. The record of the consultation indicates that GP 1 did look for signs of meningism but did not find them. This indicates that he considered the possibility of meningitis but, in the absence of meningism, decided it was unlikely.

43. GP1's account of events to me and our adviser goes substantially beyond what was recorded at the time. Some elements of what GP1 has said to me, such as his removal of Child A's nappy, have been challenged by Mrs C and her challenge has been supported by some corroborative evidence. Mrs C has expressed considerable disagreement with both the checklist and her conversation with the NHS24 nurse as well as the note made by GP 1. These circumstances put me in a very difficult position in reaching a judgment on this case. However, on balance, and given the transcript from NHS24, the note

made by GP1 at the time and the advice received from our adviser, my conclusion is that I do not have sufficient evidence to uphold the complaint.

(a) Recommendation

44. The Ombudsman has no recommendations to make on this point.

(b) The Board failed to carry out an appropriate investigation into the circumstances surrounding the examination

45. Mrs C raised her initial concerns with the Consultant Paediatrician (GP 3) who was involved in Child A's care after he was admitted to hospital, in a letter on 28 February 2005. GP 3 responded to the point he was able to on 21 March 2008 and advised that he had forwarded a copy of the original letter to the Medical Director (GP 4) of the primary care trust who oversees GPs, to enable him to look into the matter. On 5 April 2005, GP 4 wrote to Mrs C offering his condolences and confirming that he would look into her concerns and be touch when he had done so.

46. The Board's full response was provided by GP 2 on 10 May 2005. The response he provided was clear and detailed. A meeting was not offered as Mrs C lives abroad.

47. Mrs C wrote a further letter of complaint to the Nurse Director at the Board on 28 June 2005. This was acknowledged on 28 July 2005 and a letter of response issued on 25 August 2005 detailing that she considers that the issues raised by Mrs C have been responded to previously by GP 2 in his letter of 10 May 2005.

48. Mrs C complained to our office that she felt that the Board had failed to carry out an appropriate investigation into the circumstances surrounding Child A's death and that they failed to take into account NHS protocols relating to cases of suspected meningitis.

(b) Conclusion

49. I have reviewed the complaints correspondence and have obtained details of the investigations carried out into Mrs C's complaints. These show that her complaints were taken seriously. The records of the consultation were obtained and GP 1 was asked for his account of the consultation and to respond to Mrs C's concerns. Mrs C has raised concerns that evidence from CCTV could

be obtained to show that the consultation lasted a much shorter time that GP 1 claims.

50. CCTV recordings are made of these areas in the centre but they are only retained for a few days unless there has been an incident which they are required to witness. Clearly it was some time after Child A's death that the complaint was initially made and well before this time, I have been advised that the coverage had been wiped.

51. Mrs C advised that she is concerned that the Board did not carry out a full investigation into GP 1's actions given suspected meningitis. The script from the NHS24 nurse adviser did not describe symptoms which would identify meningitis nor did her 'within four hours' appointment request emergency priority. In addition to this, GP 1 did not suspect meningitis. He suspected a typical childhood infection had caused Child A's symptoms. Had he suspected meningitis he would have acted immediately to admit Child A. My review of the information has suggested that the Board carried out an appropriate investigation into the circumstances surrounding Child A's death. As a result of this I do not uphold the complaint.

(b) Recommendation

52. The Ombudsman has no recommendations to make on this point.

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
GP 1	The out-of-hours GP
Child A	Mrs C's son
The Board	Ayrshire and Arran NHS Board
GP 2	The Chief Operating Executive
GP 3	The Consultant Paediatrician
GP 4	The Medical Director

Annex 2

Glossary of terms

Meninges	Membranes surrounding the brain and spinal chord
Meningism	Signs and symptoms of irritation of the meninges
Meningitis	Inflammation of the meninges
Meningococcal septicaemia	Blood poisoning caused by the meningococcal bacterium