Scottish Parliament Region: Mid Scotland and Fife

Case 201300703: A Medical Practice in the Fife NHS Board area

Summary of Investigation

Category

Health: GP & GP Practice; clinical treatment; diagnosis

Overview

The complainant (Mrs C) raised a number of concerns about the care and treatment her son (Master A), then six and a half years old, received from the GPs at Master A's medical practice (the Practice) from May to August 2011. Master A subsequently attended Ninewells Hospital in Dundee and then the Royal Hospital for Sick Children in Edinburgh, where he was diagnosed with cancer (Burkitt's Lymphoma stage IV). He received treatment but, sadly, died.

Specific complaints and conclusions

The complaints which have been investigated are that from May 2011 GPs at the Practice:

(a) failed to provide Master A with appropriate clinical treatment in view of his reported symptoms (*upheld*); and

(b) unreasonably delayed referring Master A for a specialist hospital opinion (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Practice:	*Completion date*
(i) provide Mrs C and her husband with a written apology for the failings identified in this report; and	26 March 2014
(ii) provide my office with evidence that this case has been discussed with all GPs involved as a learning tool and that all learning points are taken forward as part of their continuous professional development.	26 March 2014

The Practice have accepted the recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. During the period May 2011 to September 2011, Master A attended his medical practice (the Practice) with symptoms of weight loss, fatigue, vomiting, nausea and bone pain. He was seen by a number of GPs at the Practice and various examinations and tests were carried out. Unfortunately, Master A's condition did not improve and in August 2011, he attended Ninewells Hospital in Dundee. On 29 August 2011 Master A was admitted to the Royal Hospital for Sick Children in Edinburgh and was subsequently diagnosed with cancer (Burkitt's Lymphoma stage IV). Master A received treatment for his cancer but, sadly, he died on 24 May 2012.

2. Mrs C and her husband submitted a formal complaint to the Practice on 18 March 2013 about the care Master A received from them prior to his diagnosis of cancer. The Practice responded on 8 April 2013. Mrs C wrote to the Practice on 3 May 2013 raising concerns about their response and they wrote back on 16 May 2013. Mrs C then submitted a complaint to my office.

3. The complaints from Mrs C which I have investigated are that from May 2011 GPs at the Practice:

(a) failed to provide Master A with appropriate clinical treatment in view of his reported symptoms; and

(b) unreasonably delayed referring Master A for a specialist hospital opinion.

Investigation

4. As part of my investigation of Mrs C's complaint, I considered Mrs C's submission to my office and reviewed the information obtained from the Practice. I obtained independent medical advice on Mrs C's complaint from a GP (the Adviser), made a further enquiry of the Practice and discussed their response with the Adviser.

5. As there is some overlap in the issues to be considered in Mrs C's complaints, I have set out Mrs C's two complaints together. However, I have provided separate decisions for each of Mrs C's complaints. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked.

Relevant guidance

6. In my investigation of Mrs C's complaint, I considered the National Institute for Health and Clinical Excellence (NICE) Guideline 27: Referral guidelines for suspected cancer (the Guidelines). Where there are no specific Scottish guidelines, as is the case here, NICE guidelines, which are national guidelines, apply. Paragraph 1.14 of the Guidelines covers cancer in children and young people and sets out the following general recommendations:

> '1.14.1. Children and young people who present with symptoms and signs of cancer should be referred to a paediatrician or a specialist children's cancer service, if appropriate.
>
> 1.14.2 Childhood cancer is rare and may present initially with symptoms and signs associated with common conditions. Therefore, in the case of a child or young person presenting several times (for example, three or more times) with the same problem, but with no clear diagnosis, urgent referral should be made.
>
> 1.14.3 The parent is usually the best observer of the child's or young person's symptoms. The primary healthcare professional should take note of parental insight and knowledge when considering urgent referral.
>
> 1.14.4 Persistent parental anxiety should be a sufficient reason for referral of a child or young person, even when the primary healthcare professional considers that the symptoms are most likely to have a benign cause.
>
> 1.14.5 Persistent back pain in a child or young person can be a symptom of cancer and is indication for an examination, investigation with a full blood count and blood film, and consideration of referral.'

7. The NICE guidelines also give specific recommendations for leukaemia and lymphomas (types of blood cancers). In this, they list symptoms which should suggest further examination or referral. These include, amongst others:

> pallor (anaemia);
> fatigue;
> persistent or unexplained bone pain;
> other features of general ill-health, fever or weight loss.

(a) From May 2011 GPs at the Practice failed to provide Master A with appropriate clinical treatment in view of his reported symptoms; and (b) From May 2011 GPs at the Practice unreasonably delayed referring Master A for a specialist hospital opinion

8. Mrs C complained about several aspects of the care provided to Master A by the Practice from May 2011 until his diagnosis of cancer on 29 August 2011. Mrs C said the Practice failed to consider Master A's history of presentation, explore Master A's symptoms further and consider other possible diagnoses. Mrs C said they incorrectly assessed and investigated pain in Master A's hip as opposed to his thigh; failed to explore further to find out what was wrong with Master A's thigh, after the x-ray of his hip failed to provide a diagnosis for his limping; and failed to repeat Master A's blood tests after the results of his tests of 8 August 2011 were received.

9. Mrs C was also concerned that, given Master A's symptoms and his deteriorating condition, the Practice should have referred Master A to a specialist sooner. Mrs C said the Practice should have recognised that Master A had 'all the red flags' which suggested that he may have had cancer and listened to Mrs C's repeated pleas for them to refer Master A to hospital.

The Practice's response

10. In their response to Mrs C's complaint, the Practice set out details of Master A's appointments and Mrs C's contacts with the Practice from June 2011 to August 2011. They then went on to try to address Mrs C's specific concerns. As both parties to this complaint are aware what was written and as Mrs C already has a copy of Master A's medical record which detail his appointments, I have not repeated this information here. However, it is important to note that in their response to Mrs C, the Practice said that following a significant events analysis of Master A's case, 'Master A presented great difficulty in diagnosis through his symptom presentation and we would have difficulty managing things differently given his symptoms and our findings at the time'. The Practice said they were sorry that they had considered Master A's bone pain to be coming from his hip and not his thigh and apologised for any additional upset and pain this had caused Master A.

Advice obtained

11. The Adviser considered the frequency of Master A's attendance at the Practice from birth until mid-May 2011. She noted that Master A had just three attendances at the Practice for health complaints and that these related to self-

limiting childhood infections. However, during the period 11 June to 24 August 2011, Master A had 13 attendances/contacts at the Practice. In addition from late May to late August 2011, NHS 24 were contacted on four occasions regarding Master A's health and he had two attendances at hospital, facts of which the Practice would have been aware. This was a total of 19 attendances at health care establishments in a young boy who had rarely attended the Practice in the six and a half years since his birth.

12. The Adviser said Master A presented with persistent / recurrent symptoms of:

limp;
anaemia;
hip/ knee pain;
gradually falling weight;
intermittent vomiting and abdominal pain.

13. Despite treatment, his symptoms did not abate and Mrs C complained of the same symptoms on repeated occasions. The Adviser said she did not feel that the Practice acted to provide a reasonable standard of care for Master A and that Master A's symptoms and number of attendances were, in her view, sufficient in volume and presentation to warrant onward urgent assessment. She said that, when viewed together, they were suggestive of an underlying organic illness. The Adviser felt that there was sufficient information in Master A's case records which should have alerted the GPs in the Practice to have a far higher 'index of suspicion'. She explained that childhood cancers were rare and that infections and viruses in children were common. The longer a child remained unwell and the more symptoms they had the likelihood that, on balance, the child had something seriously wrong increased, ie, there was a higher index of suspicion.

14. When asked whether the Practice should have explored further to find out what was wrong with Master A's thigh when the x-ray of his hip (arranged on 18 July 2011) failed to provide a diagnosis of the limping, the Adviser said an unexplained limp in a child should always be further investigated. As the x-ray was negative, a subsequent assessment by a paediatrician or paediatric physiotherapist would have been appropriate.

15. The Adviser noted that on 21 July 2011, the Practice sent a referral letter to Hospital 1 for Master A to be seen at a paediatric clinic. However, the

referral was marked 'routine' and the records show that Master A was initially given an appointment in September 2011. The Adviser noted that Mrs C contacted the Practice about the timing of the appointment and on 4 August 2011, the Practice wrote to the hospital requesting an earlier appointment. Mrs C said she telephoned the clinic, got a cancellation and Master A was seen on 10 August 2011.

16. When asked if it was unreasonable for one of the GPs at the Practice (Doctor 1) not to repeat Master A's blood test after the results of his tests on 8 August 2011 were received, the Adviser said that the haematology results form from the laboratory indicated raised plasma viscosity and platelet count. She noted that the laboratory had suggested that this may signify 'infection, inflammation or malignancy', ie, cancer, and that the tests should be repeated, although no timescale was given. The Adviser said that it was normal to see raised plasma viscosity and platelet count levels in a child with infection. She said there would be no point in the Practice re-testing a child's blood straight away, as they would need to wait to see if the levels came down themselves in order to determine if the child had an infection – ie, the levels would start to lower as the child's immune system successfully tackled the virus. If the levels did not come down when further blood tests were carried out two weeks later, then the Practice would consider it was less likely to be a virus and could possibly be something more serious. The Adviser noted that the Practice did not repeat the blood test as indicated and was critical in this regard.

17. The Adviser questioned one of the GPs at the Practice (Doctor 2)'s views in her letter to Mrs C of 3 May 2013, that raised platelet count and plasma viscosity was 'an extremely common finding' in a six year old child. When asked about this statement, Doctor 2 said this had been worded badly and she should have said the levels were raised 'for common reasons'. She explained that she had had several issues to address in a limited time and apologised for any confusion caused.

18. The Adviser noted the Practice's comments to Mrs C following the significant event analysis of Master A's case and said she found it concerning that the Practice said they would not in hindsight have managed Master A's care in a different manner and would, therefore, be concerned if a similar presentation were to reoccur. The Adviser also noted that in the 'learning' section of the copy of the significant event analysis provided to my office, the Practice said that repeat blood tests should perhaps have been undertaken

earlier than planned, despite Master A's clinical improvement. They also said that if a diagnosis had not been given by Ninewells Hospital and a trail of medication just been initiated, then perhaps an acute admission on 15 August 2011 may have been sought. The Adviser said this suggested that the Practice had concluded that, at least in terms of the blood tests, they felt they should perhaps have managed Master A's care differently. The Adviser was concerned that this had not been conveyed to Mrs C.

19. The Adviser said childhood cancers, and in particular Burkitts Lymphoma, were rare, however, they had a good prognosis with treatment. She noted that Master A's oncologist stated clearly that his treatment was curative and that he fully expected Master A to have a good prognosis. She said Master A was unfortunately one of a minority group of patients who did not respond to treatment as expected.

20. The Adviser concluded that the Practice failed to provide a reasonable standard of care for Master A and his family. She said that, despite treatments, Master A's symptoms did not abate and that, despite presentations with these persistent symptoms for three months and Mrs C's concerns that he was slowly deteriorating, Master A was not referred urgently for further investigation.

21. In line with our normal process, both the Practice and Mrs C were provided with a draft copy of my report for comment on factual accuracy. In responding, the Practice referred to the specialist opinion from the paediatrician which confirmed their diagnosis of gastritis and requested that Master A return in eight weeks' time. The Practice said they used this opinion as the basis for their on-going management of Master A. My complaints reviewer asked the Adviser to comment on the Practice's view. The Adviser said that the Practice's point had some validity. However, he explained that after the paediatric appointment the Practice retained responsibility for Master A's medical care and treatment. He noted that following the appointment Master A had a further five contacts with the Practice with worrying symptoms of vomiting, nausea and a painful hip. The Adviser said he remained of the opinion that the Practice should have recognised the significance of these persistent worrying symptoms, in particular one of the key warning symptoms of bony pain.

(a) Conclusion

22. The Adviser has explained that the Practice failed to consider Master A's history of presentation and other possible diagnoses, for example, cancer. He

has said that the Practice failed to explore further to find out what was wrong with Master A's thigh after the x-ray of his hip failed to provide a diagnosis for his limp; and failed to repeat Master A's blood tests after the results of his tests of 8 August 2011 were received. I accept the Adviser's views. The Practice have apologised for considering that Master A's pain came from his hip as opposed to his thigh. I, therefore, conclude that, from May 2011, the Practice failed to provide Master A with appropriate clinical treatment in view of his reported symptoms and I uphold Mrs C's complaint.

(b) Conclusion

23. The Guidelines state, 'in the case of a child or young person presenting several times (for example, three or more times) with the same problem, but with no clear diagnosis, urgent referral should be made'. The Adviser has said that Master A's symptoms and number of attendance were in her view sufficient in volume and presentation to warrant onward urgent assessment. The Guidelines also state that persistent parental anxiety should be sufficient reason for referral and parental insight and knowledge should be recognised when considering urgent referral. It is clear that Master A attended the Practice several times with the same problems; that Mrs C expressed repeated concerns about his condition; that the symptoms Master A was experiencing were in the list of possible symptoms of cancer; and that his health was not improving. All these factors indicate that an urgent referral would have been appropriate. It is also concerning that the routine referral made by the Practice on 21 July 2011 was only made more urgent following intervention by Mrs C herself. In light of these failings, I uphold Mrs C's complaint.

General recommendations

24. I recommend that the Practice:	*Completion date*
(i) provide Mrs C and her husband with a written apology for the failings identified in this report and offer to meet with them to re-enforce this apology; and	26 March 2014
(ii) provide my office with evidence that this case has been discussed with all GPs involved as a learning tool and that all learning points are taken forward as part of their continuous professional development.	26 March 2014

25. The Practice have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Practice notify him when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Master A	the complainant's son
the Practice	Master A's medical practice
Mrs C	the complainant
The Adviser	a GP
NICE	National Institute for Health and Clinical Excellence
the Guidelines	National Institute for Health and Clinical Excellence Guideline 27: Referral guidelines for suspected cancer
Doctor 1	one of the GPs at the Practice
Doctor 2	pne of the GPs at the Practice

Annex 2

Glossary of terms

Burkitt's Lymphoma stage IV	a cancer of the lymphatic system in which cells abnormally reproduce, eventually causing tumours to grow
Leukaemia	a type of blood cancer
Lymphoma	a type of blood cancer
Malignancy	cancer
Oncologist	a physician trained in the management of cancer

Annex 3

List of legislation and policies considered

National Institute for Health and Clinical Excellence Guideline 27: Referral guidelines for suspected cancer