SPSO decision report

Case: **202302088, A GP Practice in the Highland NHS Board area**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about the care and treatment provided to their parent (A) by the practice. A was described as fit and well but had developed severe diarrhoea. Although the diarrhoea subsided, A continued to feel unwell and breathless. A was seen by an advanced nurse practitioner (ANP) and referred for an electrocardiogram (ECG) as an outpatient a few days later. A attended for these tests, but was not seen by a doctor, and returned home. A suffered a stroke that afternoon and died in hospital the following day.

C complained that although A spoke with a doctor by telephone, they were not seen in person by a doctor over a series of appointments. C believed that A should have seen a doctor much sooner and that A should have been considered for hospital admission at their appointment with the ANP. They also said that A's ECG results were abnormal, had been misinterpreted by the practice and should have resulted in A's admission to hospital as an emergency. C believed that had the practice provided a reasonable standard of care, A's death could have been prevented. Although C met with the practice and received two responses to their complaint, they continued to believe the practice's response was inadequate and brought their complaint to this office.

We took independent advice from a GP. We found that A's care prior to their ECG was of a reasonable standard. It was noted that C disagreed with A's medical records, but it was not possible to determine precisely what was said at A's appointments. We did not uphold these parts of C's complaint.

We found that A's ECG was highly abnormal, indicating A's heart was lacking in oxygenated blood flow. This should have resulted in a face-to-face appointment, followed by an immediate hospital referral. Therefore, we upheld this part of C's complaint. However, it was not possible to determine whether A would have survived with an earlier admission as the cause of A's death was a bleed on their brain. This was an unfortunate but recognised side effect of the medication given to A to treat the stroke they had suffered.

Finally, C complained about the practice's complaint handling. We found that the practice failed to handle C's complaint reasonably and upheld this part of their complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified in this report. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.
- Apologise to A's family for the failure to provide A with a reasonable standard of care on the day of their ECG. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

What we said should change to put things right in future:

- ECG results should be accurately interpreted, taking into consideration the condition of the patient and their medical history.

In relation to complaints handling, we recommended:

- Complaint investigations should be carried out in line with the NHS Model Complaints Handling Procedure.
- The practice’s complaint investigations should ensure that failings are accurately identified.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.