Scottish Parliament Region: Glasgow

Case 201101415: A Medical Practice in the Greater Glasgow and Clyde NHS Board area

Summary of Investigation

Category

Health: GP & GP Practice; clinical treatment; diagnosis

Overview

The complainant (Ms C) raised a number of concerns about the diagnosis of her brother (Mr A)'s cancer. She complained that the health centre Mr A attended (the Practice) situated in the Greater Glasgow and Clyde NHS Board area, failed to take Mr A's complaints of back pain and reduced mobility seriously and that their lack of proactive investigation of his symptoms meant that Mr A's diagnosis was delayed. Ms C also complained about the Practice's handling of her formal complaint.

Specific complaints and conclusions

The complaints which have been investigated are that the Practice:

(a) provided Mr A with inadequate care and treatment during the months prior to his death on 26 January 2011 (*upheld*); and

(b) dealt inadequately with Ms C's subsequent complaint (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Practice:	*Completion date*
(i) consider Mr A's case with a view to improving their procedures for proactively ensuring the completion of diagnostic investigations which have been identified as necessary for their patients;	12 September 2012
(ii) draw all GPs' attention to the Adviser's comments regarding record-keeping;	12 September 2012
(iii) review the outcome of this complaint alongside their complaint procedure to avoid similar situations recurring; and	12 September 2012
(iv) apologise to Ms C and her family for the failings identified in this report.	Completed 11 July 2012

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

Main Investigation Report

Introduction

1. The complainant (Ms C) raised concerns about the treatment that her brother (Mr A) received from the health centre he attended (the Practice). Mr A attended the Practice in September 2010 complaining of back pain. He was initially advised to take paracetamol. Initial investigative tests showed no signs of infection. Further tests were carried out as Mr A's pain increased and spread to his hips. Stronger pain killers were prescribed and blood tests and x-rays were arranged, however, no significant abnormalities were revealed.

2. Mr A's GP (the GP) visited him at home in October 2010 and found that he was mobile. Ms C complained that Mr A's condition deteriorated and when she telephoned the GP in November 2010 and requested that he visit Mr A at home, the GP refused on the basis that Mr A could make his own way to the Practice. Ms C felt that the GP was dismissive of Mr A's symptoms and it was only once a social worker raised concerns about Mr A's condition that further action was taken. The GP visited Mr A at home on 16 November 2010. He was referred to hospital where, on 14 December 2010, he was diagnosed with multiple myeloma (cancer of the bone marrow). Mr A died in hospital on 26 January 2011.

3. Ms C complained to the Practice about the lack of treatment provided to Mr A. Dissatisfied with their response and their handling of her complaint, she brought her concerns to the Ombudsman in July 2011.

4. The complaints from Ms C which I have investigated are that the Practice:

(a) provided Mr A with inadequate care and treatment during the months prior to his death on 26 January 2011; and

(b) dealt inadequately with Ms C's subsequent complaint.

Investigation

5. In order to investigate this complaint, my complaints reviewer reviewed all correspondence between Ms C and the Practice. She also reviewed Mr A's clinical records and sought the opinion of one of my medical advisers (the Adviser). I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Ms C and the Practice were given an opportunity to comment on a draft of this report.

(a) The Practice provided Mr A with inadequate care and treatment during the months prior to his death on 26 January 2011

6. Mr A was 67 and was registered disabled. He attended the Practice on 30 September 2010. The corresponding clinical record noted that he had experienced lower back pain over the preceding few days and was finding it more difficult to walk. It was noted that Mr A had been taking paracetamol and that this had been helping. Mr A was advised to continue taking the paracetamol and a urine test was requested. The urine test showed no sign of infection or protein (an indicator of problems with the kidneys).

7. Mr A returned to the Practice on 5 October 2010. He was still experiencing lower back pain and it was noted that this had spread to both of his hips. The GP Mr A consulted (GP 1) recorded that Mr A had a history of elevated PSA (Prostate Specific Antigen – an indicator of possible prostate problems) and that he had not had any falls. Examination by GP 1 found that there was no localised tenderness. Mr A's pain was radiating to his groin and this was explored by examination of his abdomen and hernial orifices. Mr A was referred for an x-ray. GP 1 prescribed cocodamol for pain relief.

8. X-rays were taken of Mr A's hips and lumbar spine on 7 October 2010. The hip x-ray report stated 'Both hips are normal for age. No sclerotic metastases are seen' (a sclerotic lesion appears more dense than the surrounding bone and is common in prostatic cancer). The lumbar spine x-ray report stated 'There is minimal spondylotic change present at the thoracolumbar junction. No vertebral body collapse is seen.'

9. On 11 October 2010, another GP (GP 2) visited Mr A at his home. The clinical records stated that Mr A had been unable to attend the Practice as the belt on his trousers was hurting his back. It was noted that Mr A had been sleeping on the couch. He was advised against this. A further examination of Mr A's back was carried out. GP 2 found that the curve of his spine was normal but that he had some reduced range of movement. GP 2 concluded that Mr A was suffering from musculoskeletal pain. Ibuprofen was added to his prescription. GP 2 recommended that Mr A book in at the Practice for some blood tests.

10. Mr A telephoned the Practice on 20 October 2010 and spoke to GP 2. He asked for more ibuprofen. GP 2 explained to him during this conversation that his x-ray results had been clear (see paragraph 8).

11. On 12 November 2010, Ms C telephoned the Practice and asked GP 2 to visit Mr A at home. She said that Mr A was unable to attend the Practice due to the pain he was in. GP 2 declined her request for a house call. In her complaint to the Practice, Ms C said that GP 2 had commented that he would not make the house call as he had already visited Mr A once. Upon asking whether a nurse could attend to take blood samples, GP 2 reportedly advised that this would not be possible as Practice staff were at full stretch. In his response to her complaint, GP 2 said that he had advised Ms C that it would benefit Mr A to stay mobile and that, accordingly, he should make his way to the Practice. GP 2 noted that Mr A lived close to the Practice and was not housebound and explained that District Nurse visits were only for patients that were housebound. Ms C and GP 2 had a discussion regarding any social services that may be appropriate for Mr A.

12. On 16 November 2010, the Practice received a telephone call from the local Social Work department. The social worker raised concerns about Mr A's general health and the state of his home. A third GP (GP 3) visited Mr A at home and found that he had taken to his bed. The clinical records state that Mr A got out of bed and was able to walk to the sitting room with the aid of a stick and then back to bed without a stick. GP 3 noted that Mr A and his house were dirty and that input was required from Social Work and the Community Psychiatric Nurse (the CPN). In his response to Ms C's complaint, GP 2 said that it was too late in the working day to arrange blood samples, however, arrangements were made for another home visit the following day. Blood samples were taken by GP 2 on 17 November 2011.

13. Following another home visit on 19 November 2010, Mr A was admitted to the Southern General Hospital (the Hospital) with a temperature and signs of a chest infection. GP 2 stated that, when he realised that there had been no communication from the Hospital, he contacted them on 10 December 2010. He was advised that Mr A had had a severe rectal bleed and was under investigation. On 29 November 2010, Mr A was found to have a broken vertebrae and large spinal mass. The Hospital advised the Practice on 23 December 2010 that, on 14 December 2010, Mr A had been diagnosed with multiple myeloma. Mr A was kept in hospital for treatment but died on 26 January 2011.

14. Ms C complained that, given Mr A's history of mental illness and cognitive and hearing difficulties, Mr A's back pain should have been investigated more thoroughly than it was and staff at the Practice should have recognised how seriously ill her brother was. With regard to the home visit on 16 November 2010, Ms C said that Mr A had only been able to mobilise around his flat whilst being held by GP 3. He was unable to be mobile on his own. She noted that Mr A's spine was scanned a matter of days later and he was found to have a collapsed vertebrae and a large mass at the foot of his spine. She complained that the full extent of Mr A's illness only became clear once he was admitted to the Hospital, by which time it was too late, and she felt that the Practice could have done more to help reach an earlier diagnosis.

15. When investigating this complaint, my complaints reviewer sought the opinion of the Adviser. The Adviser reviewed the examinations and findings of the GPs during each of Mr A's consultations with the Practice. With regard to the consultations on 30 September and 5 October 2010, he was generally satisfied with the conclusions reached by the GPs and the prescriptions that were made. However, he noted that there was no record made after either examination of the absence of 'red flag' (warning) symptoms. Furthermore, the records for 30 September 2010 lacked certain information such as the presence or absence of localised bony tenderness, details regarding any previous back pain and examination of Mr A's lower limb neurology. The Adviser considered that the clinical records were deficient in terms of history and examination; however, he stated that the management and investigation of the presenting symptoms was reasonable.

16. With regard to the home visit on 11 October 2010, the Adviser again highlighted that the notes did not exclude 'red flag' symptoms. He also felt that comments such as the fact that Mr A's belt was hurting his back or that advice had been given regarding sleeping on the couch could have been expanded upon in the notes. However, he noted that the x-ray results were not known at this time and it was clear that the pain was coming from the lumbar spine rather than another organ. The Adviser, therefore, considered that the diagnosis of musculoskeletal pain was correct and the tests arranged by the GPs were designed to determine the cause of the musculoskeletal pain.

17. Commenting on the x-ray reports from 7 October 2010, and the advice given to Mr A by the Practice, the Adviser confirmed that the October 2010 x-ray reports did not suggest any significant abnormalities. He noted that Mr A

was subsequently found to have a collapsed vertebrae and spinal mass on 29 November 2010, however, he stated that his condition could have progressed between these dates.

18. My complaints reviewer asked the Adviser whether the GPs at the Practice should have recognised that Mr A was seriously ill during the period before he was admitted to the Hospital. The Adviser stated that the clinical records indicated an increasing level of concern for Mr A by family members between 20 October and 19 November 2010. The Adviser noted that the need for blood tests was highlighted in the records on 20 October 2010 and reiterated on 22 October 2010, however, no plan was suggested to realise this. On 25 October 2010, it was recorded that Mr A requested cream for his sore back and the note 'needs to be seen' was entered. Conversations with Ms C and another brother on 12 November 2010 did not result in specific action being proposed. The Adviser stated that GP 3's notes on 16 November 2010 concluding that Social Work and Community Psychiatric Nurse input was required, indicated a suspected deterioration in Mr A's mental state, however, no exploration of psychiatric symptoms was recorded and examination notes were restricted to 'got out of bed with persuasion and walked with stick to living room, then walked without stick back to bed'. The Adviser felt that it was clear that a significant change had occurred in just over six weeks, however, the notes did not include any consideration of admission to hospital or recognition of Mr A's increasing inability to cope with the activities of daily living.

19. On 17 November 2010, GP 2 visited Mr A to take blood samples. The comment 'lying in bed self-neglect ++, encouraged to mobilise' is recorded in the clinical records. No clinical examination other than these observations is recorded. On 19 November 2010, Mr A was visited again by GP 3. The corresponding records state 'lying in filthy bed and has chest infection'. Mr A was admitted to the Hospital via ambulance that day.

20. The Adviser highlighted that Mr A had complied with the Practice's advice about having his back x-rayed but had not been able to attend for blood tests. His clinical records suggested that this was unusual for him and the Adviser considered that this should have provoked suspicion, especially given the concern of family members. By mid-November Mr A was experiencing mobility problems and difficulties with self-care. The Adviser said that this was attributed to his long-standing mental health issues, but a psychiatric review on 8 September 2010 suggested that Mr A's mental state was stable.

21. The Adviser held the view that the Practice response to Mr A's changing condition and increasing incapacity was not reasonable and that consideration should have been given to hospital admission prior to 19 November 2010. He commented that it was his view that this amounted to a deficiency of care.

22. The Adviser noted that Mr A's initial presentation to the Practice was of new onset back pain with no significant history of back pain. Mr A was in his sixties and thus new onset pain at rest should have prompted investigation. Furthermore, his previous history of raised PSA should have also increased the suspicion of a significant cause of the pain. The Adviser stated a full assessment (x-rays and blood tests) plus clinical examination should have been undertaken to exclude other possibilities. Thereafter, referral for a further opinion would have been logical if (as in Mr A's case) the pain persisted.

(a) Conclusion

23. I have considered the reasonableness of the actions and conclusions of the Practice's GPs in light of the information that was available to them at the time.

24. I accept the Adviser's comments regarding the need to investigate the cause of new onset pain at rest, and how such investigations should progress. I, therefore, found it appropriate for the GPs' initial investigations to centre around blood tests and x-rays and acknowledge that the x-ray results showed no significant abnormalities in mid-October 2010.

25. As the Adviser noted, it is likely that Mr A's condition had progressed by the time he was seen at home on 11 October 2010. I do not find the diagnosis of musculoskeletal pain to be unreasonable following that examination. This correctly concluded that the source of Mr A's pain was the bones in his lower back. Further investigations would have determined the cause of that pain.

26. However, after 11 October 2010, I consider that the Practice failed to appropriately pursue the investigations which would have determined the cause of Mr A's pain. Although the x-rays were clear, blood tests were delayed. Mr A was encouraged to make an appointment for blood tests, however, samples were not taken until GP 2's home visit on 17 November 2010. The records show that Mr A made an appointment for blood tests in October 2010, but advised the Practice that he was unable to attend. This was evidently unusual

for him. In light of this, the fact that the need for blood tests had been highlighted on a number of occasions, and the concerns that were being raised by family members prior to this, I consider that the Practice could have been more proactive in obtaining blood samples from Mr A.

27. The delay in blood tests being obtained left little opportunity for further investigations which may have led to an earlier hospital admission and diagnosis. It is difficult to state exactly when the Practice should have proactively obtained blood samples. However, there were a number of indicators suggesting that Mr A's condition had declined significantly as follows:

- concerns raised by family members regarding his lack of mobility;
- Mr A's stated inability to attend the Practice in person; and
- his uncharacteristic failure to attend his blood test appointment.

28. These all lead me to conclude that a home visit should have taken place when requested by Ms C on 12 November 2010.

29. The Adviser made a number of comments regarding the Practice's incomplete record-keeping (see paragraph 18) and the suggestion from the records that the decline in Mr A's self-care was related to his long-standing mental health issues. These comments raise significant concern that investigation of the physical symptoms described by Mr A was hindered by an assumption that his problems were as much psychiatric as physical. While the GPs may have had cause to consider a psychiatric element to Mr A's condition given their observations within his home, there was a lack of follow-up either by way of referral to the CPN for investigation of a psychiatric problem, or to hospital for further investigation of a physical cause of Mr A's back pain. For these reasons, I consider that the care and treatment provided to Mr A by the Practice was inadequate and I uphold this complaint.

(a) Recommendations

30. I recommend that the Practice:	*Completion date*
(i) consider Mr A's case with a view to improving their procedures for proactively ensuring the completion of diagnostic investigations which have been identified as necessary for their patients; and	12 September 2012
(ii) draw all GPs' attention to the Adviser's comments regarding record-keeping.	12 September 2012

(b) The Practice dealt inadequately with Ms C's subsequent complaint

31. Ms C raised a formal complaint with the Practice in an undated letter, in which she listed a number of concerns about the treatment Mr A had received. The Practice responded on 11 March 2011. Ms C complained to the Ombudsman that the Practice's response did not address all the points she had raised and was also inaccurate.

32. In her complaint to the Practice, Ms C said that Mr A had a history of mental illness, hearing, communication and cognitive difficulties. She stated that, in light of this, the Practice should have investigated Mr A's back pain more thoroughly than they did. She also stated that Mr A was a regular visitor to the Practice for a range of medical complaints and she felt that they should have recognised that, on this occasion, he was seriously ill. Ms C complained to the Ombudsman that the Practice failed to respond to this particular point in their letter to her of 11 March 2011.

33. I noted from the Practice letter of 11 March 2011 that GP 2 summarised the events from 30 September 2010 leading up to Mr A's hospital admission. He stated he knew Mr A better than any other of the GPs and said he had a very good rapport with him over the years.

34. GP 2 also referred to a telephone discussion he had with Ms C on 12 November 2010. He stated he regretted that he had failed to communicate effectively with Ms C the reasons for the course of clinical action he had advised for Mr A and said this was partly due to patient confidentiality.

35. The Adviser reviewed all the complaint documents. He noted that there was a difference of opinion as to what was said during various conversations and it was not possible to be definitive about one version with respect to another.

36. However, the Adviser stated that, in his view, the Practice complaint response has some deficiencies as follows:

- the record of the home visit on 16 November 2010 and the Practice response gave a different sense of Mr A's condition. The Adviser stated that a direct quote from the clinical records would have provided better information to Mr A's family;
- no reason was given why CPN Staff were not contacted by the Practice;

- no reason was given for the delay in obtaining blood tests other than this being an issue of Mr A's non-compliance;
- no comment was made whether admission to hospital should have been considered sooner; and
- the response contained an offer to meet with Mr A's family; however, there was no reference to any other action the family may wish to take/consider (including recourse to the Scottish Public Services Ombudsman).

37. In this regard I have noted that this information was contained in the Practice 'Patient Information Leaflet - Complaints Procedure' and was appropriately referred to by the Practice Manager in her subsequent letter to Ms C dated 31 May 2011.

(b) Conclusion

38. Ms C is dissatisfied with the Practice response to her complaint. I acknowledge that the response provided a summary of the events from 30 September 2010 up to Mr A's hospital admission. However, it failed to adequately address the seven points of concern within Ms C's detailed complaint letter and, as a consequence, it failed to provide the information she sought (see paragraph 35). For all these reasons, I uphold this complaint.

(b) Recommendation

39. I recommend that the Practice:	*Completion date*
(i) review the outcome of this complaint alongside their complaint procedure to avoid similar situations recurring.	12 September 2012

General Recommendation

40. I recommend that the Practice:	*Completion date*
(i) apologise to Ms C and her family for the failings identified in this report.	Completed 11 July 2012

41. The Practice have accepted the remaining 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

Ms C	The complainant
Mr A	The aggrieved, Ms C's late brother
The Practice	The Health Centre that Mr A attended
The Board	Greater Glasgow and Clyde NHS Board
The GP	Mr A's GP
The Adviser	One of the Ombudsman's clinical advisers
GP 1	A GP at the Practice
PSA	Prostrate Specific Antigen
GP 2	A GP at the Practice
GP 3	A GP at the Practice
The CPN	The Community Psychiatric Nurse
The Hospital	The Southern General Hospital where Mr A was admitted on 19 November 2010

Annex 2

Glossary of terms

Cocodamol	A drug for strong pain relief
Cognitive	Pertaining to mental processes of perception, memory, judgement and reasoning
Hernial orifices	A bulge or protrusion of an organ through the structure or muscle that usually contains it
Ibuprofen	A pain reliever used to treat minor aches and pains
Multiple myeloma	Cancer of the bone marrow
Musculoskeletal	Affecting joints, muscles and tendons
Neurology	Nervous system
Paracetamol	A widely used pain reliever
Prostrate Specific Antigen	A protein produced by cells of the prostate gland
'Red flag' symptoms	Warning signs
Sclerotic metastases	Hardening of bone tissue
Spondylotic	Relating to posterior fusion
Thoracolumbar	Relating to lumbar parts of the spinal column
Vertebral	Spinal