Investigation Report

Investigation of a complaint against a GP Surgery in County Antrim

NIPSO Reference: 201917315

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The Role of the Ombudsman

The Northern Ireland Public Services Ombudsman (NIPSO) provides a free, independent and impartial service for investigating complaints about public service providers in Northern Ireland.

The role of the Ombudsman is set out in the Public Services Ombudsman Act (Northern Ireland) 2016 (the 2016 Act). The Ombudsman can normally only accept a complaint after the complaints process of the public service provider has been exhausted.

The Ombudsman may investigate complaints about maladministration on the part of listed authorities, and on the merits of a decision taken by health and social care bodies, general health care providers and independent providers of health and social care. The purpose of an investigation is to ascertain if the matters alleged in the complaint properly warrant investigation and are in substance true.

Maladministration is not defined in the legislation, but is generally taken to include decisions made following improper consideration, action or inaction; delay; failure to follow procedures or the law; misleading or inaccurate statements; bias; or inadequate record keeping.

The Ombudsman must also consider whether maladministration has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. A remedy may be recommended where injustice is found as a consequence of the failings identified in a report.

Reporting in the Public Interest

This report is published pursuant to section 44 of the 2016 Act which allows the Ombudsman to publish an investigation report when it is in the public interest to do so.

The Ombudsman has taken into account the interests of the person aggrieved and other persons prior to publishing this report.

TABLE OF CONTENTS

Page

Case Reference: 201917315

Listed Authority: GP Surgery, Co Antrim

SUMMARY

This complaint is about care and treatment the GP Surgery (the Practice) provided to the complainant's late mother (the patient) in April and May 2017, and from August 2019 to February 2020. The complainant said the Practice did not appropriately refer the patient for tests she considered would have led to an earlier diagnosis of mesenteric bowel ischaemia[1].

The investigation considered evidence obtained from the complainant and the Practice. It also considered independent medical advice from a practising General Practitioner (GP). The investigation did not identify any failings in the care and treatment the Practice provided to the complainant in the lead up to the diagnosis. Therefore, I did not uphold the complaint.

The investigation recognised that hospital clinicians only confirmed the patient's diagnosis in the late stages of her illness. I appreciate how difficult it was for the complainant not knowing what difference (if any) earlier diagnosis may have made to the patient's clinical pathway. While the investigation did not identify any failings, I hope it brings some reassurance to the complainant knowing that the Practice acted in accordance with relevant guidelines. I would like to offer my sincere condolences to the complainant for the sad and sudden loss of her mother.

[1] When a blockage in an artery cuts off blood flow to a portion of the intestine.

THE COMPLAINT

1. The complainant raised concerns regarding its treatment of her mother (the patient) between April 2017 and February 2020.

Background

2. The patient had a history of heart disease and chronic obstructive pulmonary disease[2] (COPD). She was a patient of the Practice for over 25 years. She attended a hospital's emergency department (ED) on 17 April 2017 with epigastric[3] pain. A general practitioner (GP (A)) telephoned the patient on 21 April 2017 to discuss her attendance. However, she was not available and the GP left a message requesting she book a routine appointment. While the patient attended a consultation on 2 May 2017, the GP felt this attendance related to her COPD and not her abdominal pain.

3. The patient attended the Practice in August 2019 reporting anxiety and weight loss. She attended consultations with both GP (A) and a second GP (GP (B)) on several occasions between August 2019 and February 2020. During this time, the patient reported symptoms including abdominal pain and further weight loss. On 4 February 2020, the complainant reported to GP (A) that the patient experienced abdominal pain and rectal bleeding. GP (A) asked the hospital to admit her for clinical investigations. The patient's condition deteriorated while she was in hospital. On 14 February 2020, the patient experienced acute mesenteric bowel ischaemia[4]. Staff performed emergency surgery in the early hours of 15 February 2020. Sadly, the patient passed away a few hours later in the intensive care unit.

Issue of complaint

4. I accepted the following issue of complaint for investigation:

   Issue 1: Whether the Practice provided appropriate care and treatment to the patient from April to May 2017, and from 27 August 2019 to 4 February 2020.

[2] The name for a group of lung conditions that cause breathing difficulties.
[3] The upper central region of the abdomen.
[4] When a blockage in an artery cuts off blood flow to a portion of the intestine.

INVESTIGATION METHODOLOGY

5. In order to investigate this complaint, the Investigating Officer obtained from the Practice all relevant documentation and its comments on the issues the complainant raised. This documentation included information relating to the Practice's complaints process.

Independent Professional Advice Sought

6. After further consideration of the issues, I obtained independent professional advice from the following independent professional advisor (IPA):

    - A practising General Practitioner (GP), MB BS FRCGP DRCOG, with over 35 years' experience in general practice (GP IPA).

7. The information and advice which informed the findings and conclusions are included within the body of this report. The IPA provided 'advice'. However, how I weighed his advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

8. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those specific to the circumstances of the case. I also refer to relevant regulatory, professional, and statutory guidance.

    The general standards are the Ombudsman's Principles[5]:

    - The Principles of Good Administration
    - The Principles of Good Complaints Handling

9. The specific standards and guidance referred to are those which applied at the time the events occurred. These governed the exercise of the administrative functions and professional judgement of those individuals whose actions are the subject of this complaint.

[5] These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.

The specific standards and guidance relevant to this complaint are:

- The General Medical Council's (GMC) Good Medical Practice, updated April 2014 (the GMC Guidance);
- The General Medical Council's (GMC) Consent: Patients and Doctors Making Decisions Together, June 2008 (GMC Guidance on Consent); and
- The General Medical Council's (GMC) Good Practice in Prescribing and Managing Medicines and Devices, April 2013 (GMC Guidance for Prescribing Medication).

10. I did not include all information obtained in the course of the investigation in this report. However, I am satisfied I took into account everything I considered relevant and important in reaching my findings.

11. A draft copy of this report was shared with the complainant and the Practice for comment on factual accuracy and the reasonableness of the findings and recommendations. The Practice did not provide any comment on the draft report.

THE INVESTIGATION

Issue 1: Whether the Practice provided appropriate care and treatment to the patient from April to May 2017, and from 27 August 2019 to 4 February 2020.

Detail of Complaint

12. The complainant was concerned the Practice failed to appropriately monitor the patient and refer her for further investigations regarding her reported abdominal pain and weight loss. The complainant also raised a concern regarding analgesia GP (A) prescribed for the patient on 10 January 2020.

13. The complainant questioned if the Practice missed opportunities to diagnose the patient's mesenteric bowel ischaemia. She explained the Practice's actions caused her to lose confidence in the medical profession.

Evidence Considered

Legislation/Policies/Guidance

14. I considered the following guidance:
    - GMC Guidance;
    - GMC Guidance on Consent; and
    - GMC Guidance for Prescribing Medication.

The Practice's response to investigation enquiries

15. The Practice said GP (A) attempted to contact the patient on 21 April 2017 following her previous attendance at the ED. It explained the patient later attended the Practice on 2 May 2017 and reported a cough, which GP (A) felt related to her COPD. It explained GP (A) did not consider the patient required referral to gastroenterology at that time.

16. The Practice said the patient attended with *'anxiousness, stress, and weight loss*' in August 2019. It explained GP (B) was concerned about her weight loss and prescribed '*build up supplements*'. He also requested blood tests, which were normal.

17. The Practice explained GP (B) asked the patient to return a number of weeks later (September 2019). It said that during this appointment, the patient did not raise any concerns and was '*reluctant to return*'. GP (B) also referred the patient to a female doctor for a gynaecological and breast examination, and advised she may require referral to hospital if her weight continued to fall.

Relevant Independent Professional Advice

18. A practising GP (GP IPA) provided me with advice on the care and treatment GPs (A) and (B) provided to the patient in April and May 2017, and between 27 August 2019 and 4 February 2020.

The complainant's response to the draft report

19. The complainant explained the patient had a history of cardiac disease and attended the Practice for over a year with '*unexplained weight loss, abdominal pain and nausea'*. She said it was 'very distressing' to see her mother in pain.

20. The complainant also explained that features in a patient's medical history are important. She felt the Practice did not fully consider the patient's clinical

medical history. She referred to the patient's ED attendance in April 2017 and explained that given her history, the GP should have diagnosed the condition earlier.

Analysis and Findings

21. The complainant referred to several of the patient's interactions with the Practice, which I consider in turn below.

April and May 2017

22. The Practice received a request from ED staff to review the patient following her attendance in April 2017. The records evidence GP (A) tried to telephone the patient regarding a review. However, she was not at home and he left a message asking her to book a routine appointment. The complainant referred to GP (A)'s attempt to telephone the patient and asked if this was sufficient.

23. The GP IPA advised he did not consider the symptoms described would normally '*trigger further action*' unless the patient reported ongoing issues. I cannot see any evidence in the records to suggest the patient booked an appointment to discuss her abdominal pain following GP (A)'s call. I also note the patient attended the Practice approximately two weeks later. However, the records suggest it related to a cough and not the abdominal pain she reported to the ED. I consider this suggests the patient did not report any ongoing issues relating to her abdominal pain to Practice staff around that time.

24. I understand the complainant's concern that this was a possible missed opportunity to investigate the patient's initial reports of abdominal pain. However, I recognise GP (A) attempted to speak with the patient but she did not proceed to make the appointment.

25. Standard 15 of the GMC Guidance requires doctors to take additional action '*where necessary*'. Having considered the records and advice provided, I consider GP (A) used his clinical judgement and appropriately concluded it was not necessary to take action in addition to his phone call. I also note the patient did not report similar symptoms again until more than two years later.

Therefore, I do not consider there is any evidence to support that GP (A)'s decision negatively impacted her clinical pathway during that time.

27 August 2019

26. The patient attended the Practice in August 2019 reporting anxiousness and weight loss. The records document GP (B) requested blood tests and arranged to review the patient again a number of weeks later. I note that at her later appointment (in September 2019), the records document the patient gained 0.2kg and her blood tests returned as normal. I also note GP (B) referred the patient to a female doctor for further examination and arranged to repeat the blood tests three months later.

27. The complainant questioned if GP (B) should have referred the patient for further tests. I note that while he referred the patient for blood tests, he did not refer her to hospital for further investigation. I note the GP IPA's advice that based on the outcome of the September consultation, there was '*no obvious reason to refer [her] for further investigation*'. I accept his advice. Based on the records and advice available, I consider GP (B) used his clinical judgement and appropriately concluded that onward referral was not necessary at that time.

December 2019

28. The patient attended the Practice on 10 December 2019. She reported feeling '*unwell*', '*sore*', and had experienced further weight loss. The GP IPA advised GP (A) referred the patient for a chest x-ray (to test for lung cancer), which he considered appropriate.

29. The patient returned to the Practice for a review on 23 December 2019. GP (A) informed the patient her chest x-ray did not show any lesions. The GP also advised the patient her blood results were normal. I note the patient reported increased abdominal pain during this consultation, and GP (A) referred her for a gastroscopy[6] and further blood tests. I again refer to Standard 15 of the GMC

[6] A procedure where a thin, flexible tube called an endoscope looks inside the oesophagus, stomach and first part of the small intestine; also referred to as an endoscopy.

Guidance, which requires doctors to take additional action '*where necessary*'. The GP IPA advised the action GP (A) took during this consultation was appropriate and I accept his advice. On this occasion, GP (A) felt it necessary to refer the patient for further tests to investigate her increased abdominal pain. I consider his actions appropriate.

10 January 2020

30. GP (B) attended the patient at home following a phone call from the complainant. The patient reported upper abdominal pain, feeling unwell, and weight loss. The complainant questioned why GP (B) did not send the patient to hospital for '*urgent investigation*' following his assessment.

31. Standard 5 of the GMC Guidance on Consent states that doctors should use their '*specialist knowledge and experience and clinical judgement'* before deciding on and discussing a plan of treatment with the patient. The GP IPA advised that in making his decision, GP (B) established the patient was clinically stable at the time of the home visit. He further advised GP (B) also would have considered she was due to attend hospital (as an outpatient) for related investigations three days after the visit. Furthermore, he was aware the patient attended ED the day before the consultation, where staff decided not to admit her to hospital.

32. The GP IPA advised that where possible, doctors should manage patients and perform relevant tests without admitting them to hospital. He also advised that GP (B)'s decision not to refer the patient to hospital on this occasion was '*entirely reasonable'* for the reasons outlined in paragraph 30 of this report. I accept his advice and consider the GP's actions appropriate.

33. The complainant was also concerned that GP (B) only prescribed the patient paracetamol during the home visit. The GP IPA advised that based on her symptoms the patient could not take anti-inflammatory medicines due to contraindication[7]. He said therefore opiates were the only other alternative.

[7] When doctors should not provide medical treatment due to the harm it would cause the patient.

34. I refer to the GMC Guidance for Prescribing Medication. It states '*you should only prescribe medicines if you have adequate knowledge of the patient's health and you are satisfied that the medicines serve the patient's needs*'. I note that at this time the patient did not have a confirmed diagnosis. The GP IPA advised that if a doctor is not confident of the diagnosis or treatment plan, it is '*unwise*' to prescribe strong painkillers. I accept his advice and consider GP (B)'s decision not to prescribe opiates on this occasion appropriate.

35. I recognise the pain and discomfort the patient must have felt at that time. I also understand how difficult it must have been for the complainant watching her mother experience that pain. However, having referred to the GMC Guidance for Prescribing Medication, I accept the GP IPA's advice that while paracetamol is not a strong painkiller, it was the '*best option*' in the circumstances. I consider that in prescribing paracetamol, GP (B) acted reasonably and in the patient's best interests.

36. The complainant raised a further concern that GP (B) did not reassure them during his visit that he was effectively managing the patient's care. Standard 68 of the GMC Guidance requires doctors to be honest with patients and consider the limits of their knowledge. I note the GP IPA's advice that as GP (B) did not know the patient's diagnosis or proposed treatment plan at the time of his visit, this kind of reassurance was '*not possible or appropriate*'. I accept his advice.

37. I fully understand how important reassurance would have been to both the patient and complainant in these circumstances. However, having referred to Standard 68 of the GMC Guidance, I consider it would have been inappropriate for GP (B) to provide assurances given his own uncertainty about the patient's clinical pathway.

4 February 2020

38. The complainant said she telephoned GP (A) and reported that the patient experienced pain and rectal bleeding. GP (A) asked the patient to attend the surgery and later referred her to the ED. The complainant asked why it took her to put pressure on the GP before he decided to refer the patient to hospital.

39. I considered if there was an opportunity for the Practice to refer the patient earlier than this date. The records document the patient attended GP (A) on 28 January 2020 and reported epigastric pain moving to her back. I note GP (A) did not send her to hospital following their consultation.

40. The GP IPA advised GP (A) appropriately managed the patient during the consultation on 28 January 2020. The consultation note documents that GP (A) was aware the patient was due to attend a consultant gastroenterologist (as an outpatient) the next day. I also note he later contacted the consultant's secretary to express his own concerns about the patient ahead of her appointment.

41. I again refer to the GP IPA's advice that it is good practice to manage patients and undertake investigations without admitting them to hospital. He advised that based on the patient's presentation, there was no reason to suggest that GP (B) should have recommended admission at that time. I also again refer to Standard 15 of the GMC Guidance and consider that GP (B) used the information available to him and appropriately concluded that the patient did not require admission to hospital at that time.

42. I appreciate the difficult situation both the patient and the complainant were in, especially given the patient's deterioration and the new symptom experienced in early February 2020. The complainant asked why it took her to put pressure on the Practice before it sent the patient to hospital. However, the records evidence that GP (A) requested admission due to the new symptom of rectal bleeding rather than because she pressured him to do so. I cannot find any evidence that would lead me to find that the Practice should have requested hospital admission for the patient earlier than 4 February 2020.

Summary

43. The complainant's overall concern was that the Practice failed to act earlier, contributing to a delay in the patient's diagnosis of mesenteric bowel ischaemia. I am aware specialists diagnosed the condition in the late stages of the illness. I appreciate how difficult it must be for the complainant not knowing if earlier diagnosis would have resulted in a different outcome. While it is unlikely to

bring the complainant and her family any comfort, I wish to draw attention to the GP IPA's advice regarding the condition. He advised it is '*non-specific with no single finding on examination or simple diagnostic test, and a long list of differential (possible other) diagnoses'*. He also advised that doctors treat the condition with surgery. However, sadly, even in situations where doctors diagnose the condition early, it has a high mortality rate.

44. I fully appreciate why the complainant has fought so hard to establish the reasons for the late diagnosis, and why she questioned the Practice's involvement. However, having considered the events leading up to February 2020, there is no evidence to indicate the Practice failed in its care and treatment of the patient. Therefore, I do not uphold this complaint.

45. I note the complainant referred to a Consultant's request for the patient's GPs to '*keep an eye'* on her following a consultation in 2016. I refer the complainant to the GP IPA's advice that the Practice's records provide '*every evidence that they did this – inviting her for smear tests and flu vaccinations, monitoring her chronic obstructive airways disease, checking her bloods and seeing her as required'*. I hope this provides some reassurance for the complainant.

CONCLUSION

46. This complaint is about care and treatment the Practice provided to the patient in April and May 2017, and from August 2019 to February 2020. I do not uphold the complaint for the reasons outlined previously.

47. Throughout my examination of this complaint, I recognised the pain and trauma the complainant experienced over the patient's sudden and unexpected death. The effect of losing a much loved mother in such circumstances is very evident in the correspondence I received. It is clear from my reading of the records how involved the family were in the patient's care. I hope this report goes some way to address the complainant's concerns. I offer through this report my condolences to the complainant and her family for their loss.

MARGARET KELLY
Ombudsman **30 March 2022**

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and with regard for the rights of those concerned.
- Acting in accordance with the public body's policy and guidance (published or internal).
- Taking proper account of established good practice.
- Providing effective services, using appropriately trained and competent staff.
- Taking reasonable decisions, based on all relevant considerations.

2. Being customer focused

- Ensuring people can access services easily.
- Informing customers what they can expect and what the public body expects of them.
- Keeping to its commitments, including any published service standards.
- Dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances
- Responding to customers' needs flexibly, including, where appropriate, co-ordinating a response with other service providers.

3. Being open and accountable

- Being open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete.
- Stating its criteria for decision making and giving reasons for decisions
- Handling information properly and appropriately.
- Keeping proper and appropriate records.
- Taking responsibility for its actions.

4. Acting fairly and proportionately

- Treating people impartially, with respect and courtesy.
- Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests.
- Dealing with people and issues objectively and consistently.
- Ensuring that decisions and actions are proportionate, appropriate and fair.

5. Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Putting mistakes right quickly and effectively.
- Providing clear and timely information on how and when to appeal or complain.
- Operating an effective complaints procedure, which includes offering a fair and appropriate remedy when a complaint is upheld.

6. Seeking continuous improvement

- Reviewing policies and procedures regularly to ensure they are effective.
- Asking for feedback and using it to improve services and performance.
- Ensuring that the public body learns lessons from complaints and uses these to improve services and performance.

Appendix Two

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

Getting it right

- Acting in accordance with the law and relevant guidance, and with regard for the rights of those concerned.
- Ensuring that those at the top of the public body provide leadership to support good complaint management and develop an organisational culture that values complaints.
- Having clear governance arrangements, which set out roles and responsibilities, and ensure lessons are learnt from complaints.
- Including complaint management as an integral part of service design.
- Ensuring that staff are equipped and empowered to act decisively to resolve complaints.
- Focusing on the outcomes for the complainant and the public body.
- Signposting to the next stage of the complaints procedure, in the right way and at the right time.

Being customer focused

- Having clear and simple procedures.
- Ensuring that complainants can easily access the service dealing with complaints, and informing them about advice and advocacy services where appropriate.
- Dealing with complainants promptly and sensitively, bearing in mind their individual circumstances.
- Listening to complainants to understand the complaint and the outcome they are seeking.
- Responding flexibly, including co-ordinating responses with any other bodies involved in the same complaint, where appropriate.

Being open and accountable

- Publishing clear, accurate and complete information about how to complain, and how and when to take complaints further.
- Publishing service standards for handling complaints.

- Providing honest, evidence-based explanations and giving reasons for decisions.
- Keeping full and accurate records.

Acting fairly and proportionately

- Treating the complainant impartially, and without unlawful discrimination or prejudice.
- Ensuring that complaints are investigated thoroughly and fairly to establish the facts of the case.
- Ensuring that decisions are proportionate, appropriate and fair.
- Ensuring that complaints are reviewed by someone not involved in the events leading to the complaint.
- Acting fairly towards staff complained about as well as towards complainants.

Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Providing prompt, appropriate and proportionate remedies.
- Considering all the relevant factors of the case when offering remedies.
- Taking account of any injustice or hardship that results from pursuing the complaint as well as from the original dispute.

Seeking continuous improvement

- Using all feedback and the lessons learnt from complaints to improve service design and delivery.
- Having systems in place to record, analyse and report on the learning from complaints.
- Regularly reviewing the lessons to be learnt from complaints.
- Where appropriate, telling the complainant about the lessons learnt and changes made to services, guidance or policy.