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PUBLIC SERVICES OMBUDSMAN FOR WALES
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The investigation of a complaint by Mr R against Hywel Dda Local Health Board

A report by the Public Services Ombudsman for Wales

Case: 201202535

Contents

Appendices

Introduction

This report is issued under section 16 of the Public Services Ombudsman (Wales) Act 2005.

In accordance with the provisions of the Act, the report has been anonymised so that, as far as possible, any details which might cause individuals to be identified have been amended or omitted. The report therefore refers to the complainant as "Mr R", Hywel Dda Local Health Board as "the Health Board" and the Out of Hours GP as "the GP".

Summary

Mr R complained about the treatment of his late wife (Mrs R) by a GP she saw as part of the Out of Hours GP service (under the governance of the Health Board). After telephoning the service Mrs R was directed to see the GP at the designated Out of Hours centre (based at a major hospital). She suffered from lymphoedema[1] to her left arm following cancer treatment and complained about feeling unwell with a developing blister rash on her left arm. The GP diagnosed shingles, giving her a prescription of a common antiviral drug. The following morning Mrs R collapsed at home and was admitted to A&E at the same hospital; she died later that day from complete organ failure as a result of sepsis.[2] Mr R complained that the GP had failed to examine his wife properly, or to diagnose her correctly. He also complained about how the Health Board had handled his complaint.

The investigation found that there was no record of the GP performing a number of basic assessments including temperature, pulse, and blood pressure. The Ombudsman's clinical advisers also found that the GP had failed to have proper regard to Mrs R's pre existing lymphoedema. Whilst Mrs R's presentation might have suggested shingles, the GP ought to have also ruled out the blisters as a symptom of sepsis given it was well known that lymphoedema had a propensity to develop infection, which could lead to sepsis. An evident failure to consider this was unreasonable. Had it been considered, Mrs R could have been given antibiotics, or admitted to hospital that day – the GP ought to have adopted a risk-averse approach. This might have affected the outcome given that prompt intervention in suspected sepsis is critical to survival prospects.

The Ombudsman also found maladministration in the Health Board's complaint handling: ranging from delays, fundamental errors in letters and no acknowledgement or response to a relevant third party. In recognition of the seriousness of the issues, the following recommendations were made, all of which the Health Board accepted:

- Written apologies to Mr R and to a relevant third party;

[1] Fluid retention and tissue swelling due to a compromised lymphatic system. Such tissue is at risk of infection.
[2] Sepsis is a life threatening condition caused by severe infection spreading from a point of origin throughout the body leading to organ failure if untreated quickly with antibiotics and fluids.

- Redress of £4,000 to Mr R for the failures identified in the care of Mrs R and £500 for the complaint handling failures;

- The Lead Clinical Director should undertake a sample review of the GP's Out of Hours clinical consultation records (minimum 6 sessions) and that all GPs delivering Out of Hours services should be reminded of the importance of performing full assessments/examinations of patients and of recording those; and that

- The Health Board should ensure it had robust measures in place to secure timely and good quality responses to complaints.

The complaint

1. Mr R complained about the standard of care and treatment provided to his late wife, Mrs R, who was seen by the Out of Hours GP on 7 May 2012, at West Wales General Hospital, Carmarthen (the Hospital). The following morning, Mrs R collapsed at home and after emergency admission to the Hospital, sadly, died there later the same day.

2. In particular, Mr R complained that the relevant GP:

- Did not properly examine his wife;
- Did not conduct a proper clinical assessment (by taking her pulse, blood pressure (BP), temperature etc);
- Failed to properly, or at all, take into account his wife's pre-existing health issues;
- In failing to take account of his wife's history prescribed her medication he ought not to have done;
- Did not reach the correct or proper diagnosis (concluding that she had shingles).

3. Furthermore, Mr R was unhappy with the way in which the Health Board had subsequently dealt with his complaint and about delays in its complaint handling.

Investigation

4. Comments and copies of relevant documents were obtained from the Health Board (which included comments from the GP concerned) and considered in conjunction with the evidence provided by Mr R. I also took advice from two of my Professional Advisers; a Consultant Physician experienced in critical care (the Adviser) and an experienced GP who has participated in Out of Hours delivery arrangements (the GP Adviser). They are Dr John Dawson and Dr Wayne Lewis respectively. Both they and I are obliged to consider what would have been a reasonable standard of care at the time events took place.

5. I have not included every detail considered or investigated in this report, but I am satisfied that nothing of significance has been overlooked.

Both Mr R and the Health Board were also given the opportunity to see and comment on a draft of this report and their comments have been taken into account in finalising its conclusions.

Relevant guidance and protocols

The General Medical Council ("GMC") Guidance

6. The GMC issues guidance to doctors on standards required of the profession. Its guidance "Good Medical Practice" includes the following:

> "2. Good clinical care must include:
>
> a) adequately assessing the patient's conditions, taking account of the history (including the symptoms, and psychological and social factors), the patient's views, and where necessary examining the patient.
>
> b) providing or arranging advice, investigations or treatment where necessary.
>
> c) referring a patient to another practitioner, when this is in the patient's best interests.
>
> …
>
> …
>
> 3. In providing care you must:
>
> (a)…
>
> …
>
> (f) keep clear, accurate and legible records, reporting the relevant clinical findings, the decisions made, the information given to patients, and any drugs prescribed or other investigation or treatment."[3]

[3] Good Medical Practice, GMC, November 2006.

The Health Board's Out of Hours arrangements and protocols

7. A patient needing to be seen outside normal GP surgery hours will access unscheduled care providers. Health Boards are responsible for commissioning and delivering such Out of Hours services. Arrangements for such services can vary. In the Carmarthenshire area of the Health Board, it is delivered by a combination of private commercial arrangements and local GPs. A private concern undertakes the call handling and initial telephone triage function and local GPs who have opted to undertake such work provide the face-to-face consultation. A dedicated centre for patient consultations is based at the Hospital, although consultations may in certain circumstances be via a home visit to the patient. In delivering this particular function, the individual GP becomes a de facto employee of the Health Board following its designated policies and procedures. The Health Board becomes corporately responsible for the GP at that time.

8. A computerised system (Adastra) is used by both the private call handlers and GPs to record information about the patient contacts. The system takes the call handler through a series of prompt questions as part of the call assessment. The call handler will then make an appointment for the patient if it is considered a face-to-face consultation is needed. Relevant information from the Adastra record for Mrs R is reproduced at Appendix 1.

9. The Health Board has written guidance for the service including general working information. A section headed "Patient Encounters" includes the following:

> "1. All necessary clinical observations should be taken as part of the clinical consultation.
>
> 2. The details of both the observations and the clinical consultations should be recorded on the call sheet to enable the patient's GP to have a full understanding of the acute episode."

10. Monitoring standards have been produced by the Health Board for both the external contractor (private call handler) and the treatment centre (GP and any other clinical staff). In order to participate in the delivery of the Out

of Hours service, the Health Board conducts pre-engagement checks of a GP with the GMC and MDU[4] as well as a monthly verification of their GMC registration. There is also a monthly review of 1% of all GP clinical consultations with learning and update opportunities as required.

The background events

Background and information from records

11. Mrs R, aged 67 at the time of events, had previously been treated for breast cancer. She had responded well to treatment which was completed a year earlier. However, she had since suffered from lymphoedema of her left arm (fluid retention and tissue swelling due to a compromised lymphatic system). This is a known complication of treatment for breast cancer either from radiotherapy and/or when the lymph nodes have been removed. Tissues with lymphoedema are also at risk of infection.

12. On **7 May 2012**, a Bank Holiday weekend, Mr R telephoned the Health Board's Out of Hours service (shortly after 9.00am) as Mrs R had been feeling unwell. A rash had developed on her left arm a few days earlier which was now blistering. Mr R queried whether she might have shingles. The call handler asked a series of designated questions prompted by the computerised system (see above) to assess the call and then spoke to Mrs R who said that she "felt lousy". An appointment for a face-to-face consultation with the GP was made for 12 noon. This was to take place at the designated Out of Hours centre based at the Hospital (see Appendix 1).

13. At the Hospital Mr and Mrs R saw the GP. Details of the consultation taken from the Adastra record are also set out at Appendix 1. It was noted to have lasted 12 minutes and Mrs R was diagnosed as suffering from shingles.[5] The GP prescribed Aciclovir (a common antiviral drug often used to treat shingles).

[4] Medical Defence Union.
[5] Shingles is caused by the same virus as chicken pox –often it is a reactivation of the virus later in the life of someone who has previously suffered from chicken pox. Shingles causes a blistering rash.

14. On **8 May 2012,** Mrs R collapsed in the bathroom at home. An ambulance was called and she was noted as arriving at the Hospital's A&E department at **11.45am**. The triage record denoted "shock" and categorised her as "red" (most urgent). The initial evaluation sheet noted Mrs R was "in peri arrest"(a serious state before cardiac arrest) and "…shut down and mottled skin". She was administered gelofusin (a blood volume expander to help raise her BP).

15. At **12.00pm** the detailed clerking record written by the Medical Registrar on duty noted as a history that four days previously Mrs R had developed an erythemous patch (reddened skin denoting injury, inflammation or infection) on her left arm and chest which evolved down her left arm and had subsequently formed blisters. It referred to the previous day's Out of Hours consultation, that Mrs R had pain in her arm and usually suffered from lymphoedema but that the previous day her arm had been discoloured. On arrival at A&E she was said to have been "mottled and very cold peripheries, BP unrecordable initially." The provisional diagnosis was "likely sepsis"[6] and possibly a clot of her left arm. Blood tests and a CT scan were undertaken and IV antibiotics administered.

16. At **2.22pm** the records show that the blood tests revealed Mrs R had a CRP[7] of 399. The Consultant on call recorded that Mrs R was "acidotic[8], septic and in renal failure" but the "source of sepsis unknown". Mrs R was to be transferred to the High Dependency Unit (HDU). The HDU consultant's record noted that the position was discussed with Mr R; Mrs R's acidosis was worsening and that she had a "poor prognosis". Mrs R continued to deteriorate and at **7.50pm** she, sadly, died. The direct cause of death was certified as "Multi organ failure" brought on by Septicaemia and that Mrs R had breast cancer. There was no post mortem so the source of infection was not positively identified.

[6] Sepsis is a life threatening condition caused by severe infection spreading from a point of origin throughout the body (septicaemia). Early antibiotic treatment is needed to prevent organ failure and death.
[7] C-Reactive Protein – an indicator in the blood to determine there is infection. A score of 399 is extremely high.
[8] Where the body is accumulating acid – a symptom of kidney failure.

Information from the Health Board's complaint file
(a) Communication with Mr R

17. On **28 June**, Mr R wrote to the Health Board to complain about the GP. It acknowledged the complaint on **4 July** stating that it would investigate his concerns and hoped to respond within 30 working days. On **31 August,** the Health Board wrote to Mr R to say it was still investigating his concerns and to apologise for the delay.

18. On **2 October,** a letter from the GP to the Health Board provided a statement with regard to Mr R's complaint. [This is dealt with fully below.]

19. On **15 October,** staff from my office's Complaints Advice Team (CAT) e-mailed the Health Board to ask when Mr R was likely to receive a response. [Mr R had e-mailed my office asking that we intervene about the delay in his getting a response from the Health Board.] This was acknowledged by the Health Board; the relevant officer would reply in due course. On **15 October,** a letter in the complaint file addressed to Mr R purported to provide a response to his complaint. However it was evidently not sent.

20. On **26 October,** staff from the CAT e-mailed the Health Board again requesting a definitive response by 31 October. My office received no acknowledgement or reply. A further e-mail was sent to the Health Board on **2 November** requesting a response by 6 November. Again no acknowledgement or reply was received. On **14 November**, a member of the CAT spoke to the Health Board's complaints team and an e-mail received the same day confirmed the position. The Health Board apologised for not responding sooner and confirmed that the officer dealing with Mr R's complaint had been on leave for a month. The letter of 15 October initially addressed to Mr R required further input and so had not been sent to him.

21. On **21 November,** my office again e-mailed the Health Board requesting an update. The same day Mr R e-mailed the Health Board (further to a telephone conversation a week earlier) to forward on an e-mail which the Health Board said it had not received. His e-mail read as follows:

> "Thank you for your phone call. I am writing to confirm my understanding of your response to the long delay in answering my initial complaint dated June 30 2012.

1. You were very sorry for the long delay.
2. Your department was not happy with the response of the line manager for the out of hours department.
3. You were happy with the response from the A&E department.
4. You gave no indication when I would receive the final report.

E-mail sent on October 18 to [named complaints officer]

5. I have asked for the name of the drug prescribed by the out of hours doctor in [the Hospital's out of hours centre] –no response.
6. A more detailed explanation of [named doctor appointed to review matter]'s role in this case – no response.
7. Confirmation that the contemporaneous computer record of my wife's consultation will be included in the report – no response.
8. I would also like to know the name of the doctor who treated my wife in [the Hospital's out of hours centre]."

22. On **22 November,** an officer from the Health Board e-mailed my office to say that a formal response had been sent for the Chief Executive's signature, on 15 November, however, the officer dealing with the complaint was away. So it was not known if this had actually been sent to Mr R yet as he had also e-mailed with further queries since his initial letter. A letter dated **19 November** was sent to Mr R as a response to his complaint. A further letter dated **5 December** was also sent to Mr R in response to his further queries (set out above).

(b) Communication with Mr R's Assembly Member (AM) / Member of Parliament (MP)

23. A letter dated **18 July** signed by the Chief Executive addressed to Mr R's AM acknowledged receipt of his letter 18 October. It stated a fuller response would be given as soon as possible. A letter dated **18 October** (marked as received 19 October) was sent from Mr R's AM enquiring about progress in investigating Mr R's complaint made four months earlier.

24. On **18 October** a letter signed by the Chief Executive was addressed Mr R's constituency MP acknowledging receipt of a letter dated 18 October to which a response would be provided as soon as possible. There was no copy of the MP's letter in the complaint file.

25. On **29 November** a letter signed by the Chief Executive was addressed to the AM. It stated that the AM's letter of 27 November would be responded to as soon as possible. There was no copy of the AM's letter in the complaint file and no copy of any further letter to the AM.

Mr R's evidence

26. Mr R said that on the 7 May his wife had been extremely unwell and in a great deal of pain on arrival at the Hospital for the consultation with the GP. Mr R said he mentioned the possibility of shingles to the GP and explained his wife had undergone chemotherapy and radiotherapy 18 months previously. However, Mr R said, the GP hardly examined her; he had to mention to him that he did not like the colour or the appearance of her breast. His wife's BP, pulse, heart rate were not taken or indeed any other test performed by the GP. Mr R said the GP spent most of the consultation on the computer and continued to type, with one finger, before turning round to say it was shingles. He produced a prescription and so they left.

27. Mr R said the medication appeared to do little to ease his wife's pain or discomfort that evening. He had spent most of the night up with her. The following morning she collapsed and Mr R said that on arrival at the Hospital he was told that she was critically ill and had no BP. Despite all the Hospital's efforts she passed away in the evening of 8 May. Mr R said he felt the GP had failed in his diagnosis of his wife's condition.

28. After complaining formally to the Health Board, Mr R said he was unhappy with the time taken to respond to him. He said he was "shocked" by the reply he eventually received which he considered failed to demonstrate that a thorough investigation had taken place despite the time taken. The response wrongly stated his wife was treated at another hospital when she had attended the Out of Hours centre based at the Hospital. He had since researched the drug prescribed to his wife and said it ought not to be given to

those who had a compromised immune system (as he said was the case with Mrs R). Despite requesting that the Health Board provide him with a copy of the computerised record of the GP consultation, it was not provided. Mr R had since sought this from his own GP practice and, he said, found it to confirm that none of the tests had been performed by the GP at the consultation. Therefore, he found it difficult to accept the review undertaken by the Health Board's investigation (finding the shingles diagnosis to be reasonable). He commented,

> "Given the lack of the most basic medical assessment, [the GP']s diagnosis could only ever have been at best lucky or at worst as it did in fact transpire, fatal. What [he] actually did was to deprive one daughter who lives in [overseas], my other daughter who lives in [England] and me the opportunity to comfort and talk to my wife before she died as she collapsed at just after 8.00am on the bathroom floor the following morning only twenty hours after being diagnosed with shingles!"

The Health Board's evidence

29. In its response of 19 November 2012 to Mr R, the Health Board apologised for the delay. The response relayed information from the GP's statement to the Health Board (see below), which was based on the computerised record (see Appendix 1). It cited a different hospital as the place of consultation.

30. The Health Board said that Mrs R's records had been reviewed by the Assistant Medical Director (responsible for primary care services including the Out of Hours service) as part of its investigation into his complaint. It was the Director's opinion that the diagnosis and treatment was appropriate save that he felt analgesia should also have been prescribed.

31. The letter of 5 December to Mr R provided the details about the drug prescribed and the identity of the GP which Mr R had subsequently requested. Otherwise, it went on to say:

> "…The Health Board is committed to providing quality responses to concerns that are raised and I am sorry that it took longer than we would usually anticipate to provide you with a response. It was remiss

of us not to keep you informed of progress and I am sorry for any additional frustration we may have caused you."

32. In its formal comments to me the Health Board reiterated that following a review undertaken of Mrs R's records, that the diagnosis reached by the GP was considered appropriate. It felt that the GP "had acted in the best interest of the patient at that time."

33. In response to an enquiry by my investigator, the Health Board confirmed that the GP had worked in its Out of Hours Service since it took over as its provider in 2004. The GP was a sole practitioner, who had worked in the area for over 25 years and had "a loyal and stable cohort of patients". It went on to say that it would "consider him to be clinically sound and the Health Board rarely, if ever, has been asked to handle complaints about his clinical care."

The GP's statement on events and the complaint

34. In his statement the GP said he was very sorry to learn of the death of Mrs R on 8 May. He repeated the information from the consultation record (reproduced at Appendix 1), adding nothing further, but going on to say:

> "Apart from breast cancer she told me she had no other ongoing medical problems and was only taking Omeprazole for Gastritis. She did not have any allergies. My examination at the time found that she was not in any acute distress. She had Oedema of the left arm and hand and a rash ? Shingles. The rest of my examination did not reveal any abnormality except for her ongoing problems. I made a diagnosis of Shingles and prescribed Aciclovir…
>
> At that time Mr and Mrs [R] appeared happy with the consultation and its outcome.
>
> It appears from Mr [R]'s letter that Mrs [R]'s condition deteriorated on the night of the 7 May 2012, when Mrs [R] was in intense pain. Mr [R] was up with her all night, but did not ask for help until Mrs [R] collapsed the following morning and was taken to the Hospital by ambulance.

I trust the above clarifies the position…"

35. In commenting on a draft of this report the GP said again how sorry he had been to learn of Mrs R's death. He recounted the meeting with her as follows:

> "I recall examining Mrs [R] although I acknowledge that my documentation of this was not explicit. I noted…oedema of her left arm and hand in addition to a blistering rash which I felt was likely to be shingles…The intervening skin was not discoloured in any way at that time and the local temperature of her skin was not raised. I also recall listening to Mrs [R]'s heart and lungs and this part of my examination was normal. Mrs [R] was not tachycardic. I have recorded 'rest nad' in the clinical record which indicated that, other than the signs in Mrs [R]'s arm her examination was normal. I acknowledge that I should have recorded her examination fully, including any relevant negative findings and I apologise for not having done so…
>
> …In view of the concerns that have been raised by this complaint, I have reflected on the care I provided at length. At the time I saw Mrs [R], although I was aware that she felt unwell, she was not acutely unwell, being able to engage fully with me. In view of the signs she was displaying I felt that she had shingles and there were no physical signs of a more severe infection at that time. I note that Mrs [R] however deteriorated several hours after I saw her and I was very sorry to hear this…"

Professional advice

36. Having reviewed the clinical records and complaints correspondence **the Adviser** commented that it was clear the Hospital diagnosed sepsis at Mrs R's admission on 8 May – there was no mention of shingles in the initial diagnostic list. The subsequent blood test result with a CRP of 399 was very high and this was a marker for sepsis. Whilst the actual cause of septicaemia was not documented (the scans undertaken revealed no pointers), and no post mortem was performed, the Adviser said that lymphoedema is commonly

associated with infective complications (cited in standard medical textbooks).[9] The described clinical signs in the arm were compatible with spreading sepsis, and so the likely source of infection. Infective cellulitis[10] can cause blistering particularly in the presence of oedema.

37. From the documentation the Adviser concluded that Mrs R had died from multi-organ failure due to sepsis probably originating in Mrs R's arm which had the complication of lymphoedema secondary to radiotherapy. However, what he could not definitively say, from the documentation alone, was whether the sepsis was blistering cellulitis, or secondary infection of shingles blisters. A post mortem might have established whether Mrs R actually had shingles. However, he went on to say that even if Mrs R had had shingles, given her clinical history, it should have been borne in mind that sepsis could occur secondary to the infection of shingles blisters.

38. In relation to the actual events of 7 May, therefore, the Adviser was very clear that the possibility of sepsis could and should have been considered by the GP at the consultation for the following reasons:

- The telephone triage record noted Mrs R had commented "she feels lousy".
- This should have prompted some comment on systemic symptoms by the GP.
- A record of the temperature, pulse, BP and clinical signs should also have been made (there was no evidence these were performed and Mr R says they were not).
- The known propensity of lymphoedema to develop cellulitis and other infections should have been considered.
- Such a consideration should then have led to a consideration of sepsis - at least as a differential diagnosis - irrespective of any consideration of shingles as a primary diagnosis, given Mrs R's known clinical history.
- Had this been considered either an admission to the Hospital that day could have been arranged, or, at the very least, Mrs R would have been prescribed antibiotics at the consultation.

[9] e.g. Oxford Textbook of Medicine 5 edition 2011
[10] Severe skin inflammation which can be infected

39. The Adviser went on to explain that early administration of antibiotics is critical in the prompt treatment of sepsis; severe sepsis carries a high mortality so survival depends on early identification and treatment with antibiotics and fluids. Whilst the diagnosis of shingles may have been reasonable in itself, what was not reasonable, in the Adviser's view, was excluding a diagnosis of sepsis in the circumstances known at the time. He was of the firm conclusion that:

> "...Failure to diagnose sepsis, whether a primary complication of the lymphoedema, or secondary to shingles, delayed treatment for 24 hours and represented a failure of the opportunity to treat, which may have led to survival."

40. Finally, the Adviser said that the drug prescribed to Mrs R at the consultation on 7 May (Aciclovir) was appropriate to treat shingles. There were no contraindications to this drug for someone such as Mrs R; it was not inappropriate to prescribe it. Such a dose would be unlikely to aggravate her sepsis.

41. The **GP Adviser** was critical of the initial assessment recorded by the GP at the 7 May consultation. There was no systemic assessment of Mrs R and in that respect he agreed with the view advanced by the Consultant Physician Adviser above. He commented that:

- The GP failed to carry out (and/or failed to record) a number of basic assessments (temperature, pulse, BP etc).
- The Health Board's own protocols required that clinical observations – i.e. certain assessments - should be undertaken as part of the clinical consultation (see paragraph 9 above).
- The GMC's guidance specifically required that there was an adequate assessment of the patient.

42. In conclusion, the GP Adviser was of the clear view that:

> "The initial assessment of the patient was inadequate and a service failure. This failure may have had serious consequences for the patient and may have affected her chances of survival from sepsis."

Analysis and conclusions

43. Firstly, I would like to acknowledge that the circumstances of Mrs R's sudden death will have been very upsetting for Mr R and the family. In order for me to uphold a complaint, there must be evidence to suggest that there has been service failure (and/or maladministration) on the part of the body complained about which has caused an injustice to the complainant. In reaching my findings I have been guided by the advice of both my Professional Advisers, and I am grateful to them for their clarity.

44. One reason I concluded that the facts of this case warranted the issue of a public report is the current view that Out of Hours services adopting a risk-averse approach are contributing to waiting times and delays at A&E departments. This complaint, however, portrays the exact opposite. If a risk-averse approach had been adopted it would have potentially led to a different outcome. It has also raised important issues about governance.

(a) Complaints about the care and diagnosis by the Out of Hours GP

45. Both my advisers have been very clear in their advice about the GP in this case. I have set out their views above so I need not repeat them at length here. However, I do want to expand on a couple of points. Whilst neither can say, at this remove, whether or not Mrs R actually had shingles, or that as one possible diagnosis it was per se inappropriate, the critical issue was Mrs R's other documented symptoms and her known clinical history (conveyed to both the call handler and the GP directly at the consultation). This was sufficient to have warranted a reasonable clinician to consider sepsis – it is explicitly referred to in standard available medical textbooks. After all, it may be obvious to point out, the rash and blisters appeared on the very arm in which Mrs R suffered from lymphoedema. This ought to have triggered some consideration given that infection and cellulitis is a well known complication. As the Adviser points out, it should have led to a consideration of sepsis even if (my emphasis) it was felt Mrs R might have shingles.

46. To the impartial reader of the record at Appendix 1, it appears it was Mr R who advanced shingles as a suggestion (both to the call handler and GP) and this was taken as the likely diagnosis without further tests and assessments. Failing to undertake them was wrong and a severe

shortcoming on the GP's part as identified by both advisers. In his additional comments (paragraph 35), having seen a draft of this report, the GP now says he did undertake them albeit failed to record them (a fact not noted in his original comments). I am not overly persuaded by this.

47. It is worth remembering that the call handler is not clinically trained, so any suggested diagnosis within the call record is not reliable. The face-to-face GP consultation and assessment is of the utmost importance; not least because an Out of Hours GP has no detailed knowledge of the individual patient. In this instance there was sufficient information known about the patient's clinical history from the call handler to have made the link about probable sepsis, but the GP failed to do so. The lack of proper assessment and basic tests simply compounds that failing.

48. The prompt and timely administration of antibiotics in Mrs R's case may have made a difference. The GP could have prescribed her antibiotics that day. The loss of that opportunity to survive is very real albeit the eventual outcome cannot now be known for certain. It is, perhaps, all the sadder that Mrs R was in fact seen at the same Hospital on 7 May that she would be admitted to the next morning. Had the GP given any consideration to sepsis a second opinion could very easily have been obtained that day, if only to rule it out, by referring her there. It is a perfect example of when it is appropriate to adopt a more risk-averse approach. Mrs R's chances of survival if she had been admitted to the Hospital that particular day, I believe, would have been better, although again there can be no certainty as to the outcome. Nevertheless, the failings identified leave me in no doubt; **I uphold** Mr R's complaint about the failure in care and diagnosis of his wife by the Out of Hours GP.

49. I am concerned that in its own review of events the Health Board said it did not consider there to have been failings. Both my advisers were left in no doubt that the assessment of the patient was wholly inadequate. I agree. Whilst the failing may be an isolated one for this particular GP, it was a critical one, and a fundamental failing. I would have expected the Health Board to recognise this given what is stipulated in its own procedures (see paragraph 9 above). That is an issue of governance.

50. Finally on the clinical issues, the Adviser's advice is very clear on the drug prescribed that day. If Mrs R indeed had shingles Aciclovir was the correct drug. If she did not have shingles, it would not have compromised her or made the sepsis worse. **I do not uphold** Mr R's complaint about the actual prescription. The GP's prescribing failure was arguably in not prescribing antibiotics as well.

(b) Complaint about the Health Board's handling of Mr R's complaint

51. I have set out details about the background to this in paragraphs 17-25 above. Suffice to say that the Health Board did not, in my view, deal with Mr R's complaint in a proper or timely manner. It has, to its credit, acknowledged this in its letter to Mr R of 5 December (see above). Apart from the delay in his receiving a substantive reply (almost five months after Mr R first complained) it would appear that this had to be elicited by prompts from the AM and possibly the MP (although there may have been a muddle as to which had written – see below). It also required intervention from my office. There were instances of no acknowledgments to legitimate enquiries made by my staff on behalf of Mr R before this investigation began, an issue I take very seriously, as well as a lack of evidence that the AM (or MP) ever received any substantive reply to their letters.

52. The copy complaints file provided, upon my investigator's request for sight of it, also highlighted a number of problems. It contained no copy of any letter received from the MP at all, albeit he was apparently sent an acknowledgement to a letter on the same date as his was written (18 October). The AM was sent (apparently) a letter dated 18 July that predated the letter he actually wrote (18 October), a copy of which was in the complaints file. Both copy letters from the Health Board bore the Chief Executive's signature denoting they would have (probably) been sent. As Mr R pointed out the response from the Health Board to him also referred to the wrong hospital. This level of basic inaccuracy in correspondence is unacceptable and reflects poorly on the Health Board. It is maladministration and a service failure. It conveys a lack of care and, to a complainant, a lack of proper attention to their complaint.

53. It is also regrettable that in his statement on the complaint the GP's final sentence could be perceived as a criticism of Mr R for not seeking help earlier during the night of 7 May (see paragraph 34 above). That is somewhat insensitive and was, I feel, an unnecessary comment in the circumstances of the case. **I uphold** Mr R's concerns about complaint handling. The failure to provide a timely response - even to legitimate enquiries from third parties (including my office) - as well as the fundamental errors in letters suggests a lack of overall scrutiny of the quality of complaint responses. That is a governance issue. I note that the Health Board has offered its apologies to both Mr R and to my CAT staff for the delays. However, if what I am forced to conclude above is correct (from the evidence in the complaints file provided to me), I cannot see that it has extended any similar apology to the AM (or the MP).

54. I regret that reading my conclusion that Mrs R lost an opportunity of surviving the septic episode will undoubtedly add further to the family's continuing distress. There is no doubt that the service failures identified have resulted in an injustice to Mr R and the family. I have a number of recommendations to make in this case which I set out below. I would like to stress that the financial redress I am minded to recommend is in no way to be seen as compensation for the family's loss.

55. I am conscious that the GP in this instance is a sole practitioner; he is an experienced GP of many years standing. This makes the inadequacy of his assessment and recording of it on 7 May potentially a cause for greater concern. For that reason, I consider there needs to be a more extensive review of his assessments. The Health Board's protocol (see paragraph 10 above) states that a sample review (1%) of consultation records is undertaken, as part of its monitoring arrangements. In this instance, I am of the view that the sample for this GP (if he is to continue delivering the Out of Hours service) should, for a period of time, equate to higher than the usual 1%; specifically when dealing with acutely ill patients. A demonstration of appropriate assessment within the Out of Hours service ought to provide reassurance of good assessment within his GP practice caseload.

Recommendations

56. I recommend that, within one month of this report unless otherwise stated:

(a) The Health Board apologises in writing, through its Chief Executive, to Mr R and the family for the failings identified and also to the Assembly Member for not providing a full response to his enquiries.

(b) The Health Board offers Mr R redress in the sum of **£4,000** in acknowledgement of the missed opportunity in Mrs R's case, with the continuing distress this causes Mr R, together with **£500** in recognition of his time in pursuing his grievances and the complaint handling failures.

(c) The Health Board should remind GPs delivering the Out of Hours service (and this GP in particular) of the importance of carrying out full assessments/examinations of patients and of recording them. I also recommend that the GP in this case should reflect on the findings in this report and discuss and critically review it within his appraisal. Evidence that this has been carried out should be provided to my office within one month of its completion.

(d) The Health Board's Lead Clinical Director should for a period undertake a larger sample review of the GP's Out of Hours clinical consultation records (minimum of 6 sessions delivered) paying critical attention to consultations dealing with the acutely ill patient. Within one month of completing this it should report to me its findings and any actions it proposes to take if shortcomings are identified.

(e) The Health Board should ensure it has robust measures in place within its complaints department to secure the quality and timeliness of responses.

57. I am pleased to note that in commenting on the draft of this report the Health Board has agreed to implement these recommendations.

Peter Tyndall 14 August 2013
Ombudsman

Appendix 1

Extracts from the "Adastra" record for Mrs R (7 May 2012)

(A) Call / Triage Entry

"…
Call origin: Husband
Appointment: 07/05/2012
Priority on Reception: Routine
…
Reported Condition:
Symptoms: Husband thinks she has shingles
Comments: Has finished chemo a year ago
…
…
TAS Assessment
Start type: Advice
Rash

Onset; 1-3 days
Current state: Normal/Alert
Areas of Rash: Generalised
Appearance: Blisters
Rash Colour: Red
Rash Itch/ Pain: Unsure
Rash/ Glass Test: Fades if press
Skin Discharge: None
Pain/Swelling: No
Temperature: Not assessed
Cold/flu–severity: None at all
Urinary Symptoms: No
Other Symptoms: None of listed
Allergic React: No
Tropical Travel: None
Contacts at Risk: No
ChPox/Shingles: Poss shingles
PMH/Skin Disease: None
Meds/Skin Disorder:None
Spoke to PT Re? Shingles.

Says feels lousy and somewhat reluctant to attend PCC[11] but following discussion happy to take the 12pm appt.

Please assess and advise.
Thank you.
[History] CA Breast
[Medication] None
[Allergy] None
Symptoms: husband thinks she has shingles. Comment: has finished chemo a year ago.
Seek further professional advice if symptoms worsen or you are worried.
…"

(B) The GP's entry

"

Adastra Consult by: [the GP] **Consult Start:** 11:36
Start Type: PCC **End Type:** PCC **Consult End:** 11:48
History:
Suffers from Breast cancer and has had chemo and radiotherapy which finished last year – has lymphoedema of the left arm and is under lymphoedema clinic in PPH – developed pain down the left arm and in front of chest 2 days ago and now has come out in a blistering rash on the arm and hand. No other ongoing medical problems, takes omeprazole for gastritis- no allergies

Examination
Not in any acute distress –oedema of left arm and hand ++ rash ?shingles+ rest nad [no abnormalities detected] except for ongoing problems

Diagnosis
Shingles

[11] Primary Care Centre- the designated Out of Hours centre at the Hospital

Treatment
Aciclovir 800mg five times a day – see pm fu [follow up] with GP

Clinical Code(s)
A53. Herpes Zoster
…
Informational Outcome(s)
Reassessment : To Be Done By Own Surgery – see pm fu with GP."

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