



Northern Ireland

Public Services

Ombudsman

Investigation of a complaint against a GP Practice

Report Reference: 202005702

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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.

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Case Reference: 202005702

Listed Authority: A Medical Practice

SUMMARY

This case was about care and treatment the Practice provided to a complainant's late wife (the patient) during a consultation on 29 December 2022, and in the days following, up until 1 January 2023.

The patient contacted and attended the Practice on 29 December 2022. Her condition worsened and she was admitted to hospital on 1 January 2023. She sadly passed away a month later. The complainant believed the Practice incorrectly diagnosed the patient with an upper respiratory tract infection and failed to prescribe her antibiotics. He also said the Practice failed to contact the patient with the results of a blood test and questioned the advice provided to her.

The investigation found the Practice acted in accordance with guidance and provided appropriate care and treatment to the patient. It found the Practice attempted to update the patient with the results of the blood test and provided appropriate advice to the patient.

I extend my deepest condolences to the complainant and his daughters for the loss of his wife, and their mother.

THE COMPLAINT

1. This complaint was about care and treatment the Practice provided to the complainant's 71-year-old wife in December 2022 and January 2023. The patient sadly passed in hospital on 1 February 2023, leaving her family "*completely devastated*".

Background

2. The patient felt unwell for several days and complained to her family of "*flu-like symptoms*" prior to Christmas 2022.
3. The patient's condition worsened from 26 December 2022, and she telephoned the Practice on 29 December 2022. She arranged for a consultation later that morning. The Practice diagnosed her with an "*upper respiratory tract infection*"¹ and prescribed a nasal spray² for "*relief of symptoms*".
4. The complainant said the patient's condition deteriorated. On the evening of 1 January 2023, she attended an out-of-hours (OOH) service³. The OOH doctor examined the patient and made a diagnosis of possible "*pneumonia*"⁴, "*hyponatremia*"⁵, and "*hypokalemia*"⁶.
5. The OOH doctor referred the patient to the Emergency Department and a clinician admitted her to a ward on 2 January 2023. She sadly passed in hospital on 1 February 2023. The hospital recorded the cause of death "*multi-organ failure*"⁷ due to (or as a consequence of) "*bilateral pneumococcal pneumonia*"⁸ due to (or as a consequence of) "*hypothyroidism*"⁹."

¹ An infection of the upper airways usually caused by a virus.

² Used to deliver medications locally in the nasal cavities.

³ Service for patient care outside of GP surgery and pharmacy opening times.

⁴ Infection of the air sacs in one or both lungs.

⁵ Low sodium levels in the blood.

⁶ Low potassium levels in the blood.

⁷ When one or more of your vital organs stops functioning.

⁸ A form of bacterial pneumonia.

⁹ A disorder of the thyroid gland resulting in production of insufficient thyroid hormones.

6. The complainant raised concerns with the Practice on 13 March 2023 regarding care and treatment it provided to the patient. The Practice responded to the complainant on 24 May 2023. The complainant contacted my office on 19 October 2023 as he was dissatisfied with the Practice's response to his complaint.

Issue of complaint

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

Whether the Practice provided appropriate care and treatment to the patient during, and following, her consultation on 29 December 2022.

INVESTIGATION METHODOLOGY

8. In order to investigate this complaint, the Investigating Officer obtained from the Practice all relevant documentation together with its comments on the issues the complainant raised.
9. The Investigating Officer also obtained records from the relevant Health and Social Care Trust which oversaw the testing of the blood sample, as well as notes from the Out of Hours GP service.

Independent Professional Advice Sought

10. After further consideration of the issues, I obtained independent professional advice from the following independent professional advisor (IPA):
 - A General Practitioner with over 30 years' experience in a general Practice, and a member of the Royal College of General Practitioners. Holds following qualifications: Mb, ChB, DCH, MRC, and GP.

I enclose the clinical advice received at Appendix two to this report.

11. 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 this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

12. 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 Principles¹⁰:

- The Principles of Good Administration

13. 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.

The specific standards and guidance relevant to this complaint are:

- The General Medical Council's Good Medical Practice, updated November 2020 (the GMC Guidance);
- Public Health Authority for Northern Ireland (PHA NI) "Do I Need an Antibiotic" (undated) (PHA guidance on antibiotics);
- The National Institute for Health and Care Excellence (NICE) Pneumonia in adults: diagnosis and management Clinical Guideline 191 updated July 2022 (NICE CG191);
- National Health Service (NHS) fact sheet on Respiratory Tract Infections (RTIs), 28 April 2021 (NHS guidance on RTIs);

¹⁰ These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.

- The National Institute for Health and Care Excellence (NICE) Clinical Knowledge Summaries for Chest Infections-adult, published 1 May 2019. (CKS guidance on chest infections);
- The National Institute for Health and Care Excellence (NICE) Cough (acute) antimicrobial prescribing (NG120), 7 published February 2019. (NG120);
- National Health Service (NHS) fact sheet on Beclometasone nasal spray 16 March 2020. (NHS Beclometasone fact sheet);
- Medical Defence Union (MDU) Journal article ref Good Safety Netting Practice 11 March 2016 (MDU Journal);
- The British Medical Journal (BMJ) article on “Safety-Netting in the Consultation” 25 July 2022 (BMJ Safety Netting article); and
- National Health Service (NHS) High temperature (fever) in adults, 24 May 2020 (NHS guidance on high temperature).
- National Health Service (NHS) Haematology Reference Ranges, November 2020 (NHS guidance on blood ranges);
- Association for Laboratory Medicine (ALM) White Blood Cell Count, 24 July 2018 (ALM guidance on white blood cell count); and
- NIdirect guidance on pneumonia, undated, (NIdirect guidance on pneumonia)

I enclose relevant sections of the guidance considered at Appendix 3 to this report.

THE INVESTIGATION

Whether the Practice provided appropriate care and treatment to the patient during and following her consultation on 29 December 2022.

The appropriateness of the actions taken during the consultation process, including the diagnosis of an upper respiratory tract infection

Detail of Complaint

14. The complainant said the patient displayed “*obvious red flag symptoms of pneumonia*” which the Practice “*did not pick up*”. The complainant said he knew from experience what the symptoms of pneumonia were and said the patient “*was experiencing up to seven of the symptoms*” including “*very fast and shallow breathing.*” The complainant said the patient was unable “*to maintain normal conversation*” as she had “*such difficulty breathing*”.
15. The complainant said there was a “*lack of observations carried out*” on the patient when the Practice examined her. He said there was “*no reference to the patient’s breathing rate being checked or indeed any other observations that you would expect a doctor to have noticed*”.
16. The complainant said if the Practice “*had acted on the side of caution and requested an x-ray or even an antibiotic*” the outcome “*may have been different*”. He also said if the Practice had “*considered*” the “*information available from previous X-ray*” then “*this may have led to a better diagnosis*”. The complainant said the Practice diagnosed the patient with a “*respiratory tract infection*” and this was “*an incorrect diagnosis*”.

Evidence Considered

Legislation/Policies/Guidance

17. I considered the following policies and guidance:

- The GMC Guidance
- NICE CG191
- NG120
- CKS guidance on chest infections
- NHS guidance on RTIs

- NHS Beclometasone fact sheet
- NHS guidance on high temperature
- NHS guidance on blood ranges
- ALM guidance on white blood cell count
- PHA guidance on antibiotics
- NIdirect guidance on pneumonia

Practice’s response to investigation enquiries

18. As part of investigation enquiries, the Practice had an opportunity to respond to the complaint. The Practice said:
19. The patient presented on 29 December 2022 with symptoms of “*an upper respiratory tract infection*” which included “*normal pulse, oxygen saturations and blood pressure with reassuring bloods*”. With this overall picture there was “*no indication*” to prescribe antibiotics or refer for chest x-ray.
20. The patient “*did not describe typical symptoms of pneumonia such as any coloured or bloody sputum¹¹, fever/chills, shortness of breath, rapid breathing and chest pain*”. There was no “*clinical indication*” to predict the patient’s rapid deterioration due to an “*evolving aggressive pneumococcal pneumonia*”. It also said there was “*no indication that [the patient’s] respiratory rate was elevated*”.

Relevant Practice and medical records

21. I considered the patient’s medical records for the period of December 2022 and January 2023. The Practice also provided my office with a recording of the telephone call the patient made to the Practice on 29 December 2022.
22. I also considered the patient’s records with the Out of Hours GP service for 1 January 2023.

¹¹ Also known as hemoptysis. A mixture of saliva and mucus with visible streaks of blood.

Relevant Independent Professional Advice

23. I enclose the IPA advice received at Appendix two to this report.

Responses to the Draft Investigation Report

24. Both the complainant and the Practice were given an opportunity to provide comments on the Draft Investigation report. Where appropriate, comments have either been reflected in changes to the report or are outlined in paragraphs 30 and 33 below.

The Complainant's Response

25. The complainant highlighted his belief the patient was “*very unwell*” prior to her consultation with the Practice on 29 December 2022. He said the OOH GP made a “*firm*” diagnosis of pneumonia on 1 January 2023 and not a “*possible*” diagnosis as referenced in paragraph 4. He also queried why the Practice did not make similar diagnoses of low sodium and potassium in the patient as the OOH GP.

The Practice Response

26. The Practice had no significant amendments.

Further Independent Professional Advice Following receipt of Draft Investigation Report Responses

27. In consideration of the complainant's comments in response to the Draft Investigation Report, the IPA provided further independent professional advice. The additional advice relates to the meaning of the diagnosis reached by the OOH GP on 1 January 2023 as well as the appropriateness of the diagnosis made by the Practice on 29 December 2022. He also advised on how a URTI

can develop into pneumonia. The IPA's additional advice is provided at Appendix four to this report.

Analysis and Findings

28. The complainant raised concerns about the Practice's treatment of the patient in December 2022. He said the patient had an elevated respiratory rate on 28 December 2022 and was "*unable to maintain normal conversation*". I considered the recording of the patient's telephone call to the Practice the following day, on 29 December 2022. The patient did not raise any concerns about her breathing during the call. She stated she had taken "*a bad cold*", she had "*a really bad sore throat*", her nose "*streamed for three days*", she was "*sort of dizzy*" thinking it to be "*vertigo*", she had a "*thick head*" and with a "*really dry*" mouth.
29. The complainant said when the patient attended the Practice, there was a "*lack*" of observations carried out, including her "*respiratory rate*". The GMC Guidance requires doctors to "*provide a good standard of practice and care*" and to "*adequately assess the patient's conditions, taking account of their history (including the symptoms)*". The IPA reviewed the medical notes and advised the Practice recorded the patient's temperature, pulse rate, and blood pressure. He also said the Practice recorded the patient's chest was "*clear*", she had "*no leg swelling*", her ear drums were "*dull*", her throat looked "*normal*", although her mouth "*was dry*". The IPA advised the Practice carried out the "*appropriate*" observations of the patient. He advised this was a "*targeted examination*" of the patient "*based on her presenting symptoms*". He further advised it was "*appropriate*" the Practice had not recorded her respiratory rate. I accept that advice and consider the Practice met the relevant GMC standard.
30. The complainant said the patient displayed "*obvious red flag symptoms of pneumonia*". He also said the diagnosis of an upper respiratory tract infection on 29 December 2022 was a "*wrong diagnosis*". He stated the OOH GP

examined the patient on 1 January 2023 and made a “*firm diagnosis of double pneumonia*”. The IPA advised the Practice’s diagnosis of an upper respiratory tract infection on 29 December 2022 was “*consistent with the presenting symptoms and examination and observational findings*”. I have considered the symptoms complained about by the patient herself in the telephone call she placed to the Practice (referenced in paragraph 24), and also the condition of the patient as recorded by the Practice during the consultation. I have taken into account the CKS guidance on chest infections and accept the advice of the IPA that the diagnosis of an upper respiratory tract infection was “*consistent*” with the manner in which the patient presented at the time of the consultation. The IPA reviewed the diagnosis made by the OOH GP on 1 January 2023 and advised it was a “*tentative*” diagnosis where pneumonia was “*suspected*” but not “*confirmed*”. He advised a definitive diagnosis could only be confirmed by a chest x-ray in the hospital. Having review the records and NICE CG191, I accept that advice.

31. The Practice took a sample of blood from the patient on 29 December 2022. This blood sample was tested at Altnagelvin Hospital. The results showed the following:
 - White cell count - $7.64 \times 10^9/L$ (normal range between $4-10 \times 10^9/L$).
 - Neutrophil count of $6.87 \times 10^9/L$ (normal range between $2-7 \times 10^9/L$).
32. Based on these results, the patient’s white cell and neutrophil counts both lay within the normal range. ALM guidance on white blood cell count states an elevated white cell count is “*frequently a sign of an inflammatory response, most commonly the result of infection*”. The IPA advised the patient’s white cell count was “*normal*”. Therefore, at that time, there was “*no evidence*” of “*an acute bacterial infection such as pneumonia*”. I accept that advice.
33. The complainant said the OOH GP made reference to the low sodium and potassium levels of the patient on 1 January 2023 and queried why that was “*not picked up*” by the Practice on 29 December 2023. The IPA reviewed the diagnoses the OOH GP made in respect of the sodium and potassium levels and advised it was only possible for the OOH GP to have made this diagnosis

because of the blood tests taken by the GP on 29th December and therefore the GP could not have made the diagnosis as he had to await the results of the blood tests.

34. The complainant said the Practice should have taken an X-ray of the patient. The GMC Guidance states if a doctor assesses or diagnoses a patient, then the doctor “*must promptly provide or arrange suitable.....investigations....where necessary*”. The CKS guidance on chest infections states “*chest X-ray may be helpful to rule out pneumonia, but it is not normally initially necessary*”. NICE CG191 states it is “*in hospital*” that pneumonia is “*usually confirmed by chest x-ray.*” The IPA advised “*there was no clinical indication for a chest x-ray or other investigations to be ordered as her symptomology and clinical findings were consistent with a diagnosis of a URTI (upper respiratory tract infection).*” I accept that advice and consider the Practice met the relevant GMC standard.
35. The complainant said the Practice should have referred to the patient’s previous x-ray images as it may have “*influenced*” the diagnosis. The IPA advised he would not have expected previous x-ray results to have been considered unless “*there was some specific clinical reason to do so such as more marked respiratory symptoms and signs on her chest at that time*”. I accept that advice and consider there was no requirement to review the patient’s previous X-rays.
36. The complainant said there was a “*missed opportunity*” to prescribe the patient antibiotics. The GMC guidance states a clinician “*must prescribe drugs or treatment...only when you are satisfied that the drugs or treatment serve the patient’s needs.*” I reviewed the medical records and note the Practice prescribed the patient Beclometasone¹² 50 ug nasal spray. The NHS Beclometasone factsheet advises the nasal spray “*reduces swelling, mucus, itching and irritation in your nose*”. As referenced in paragraph 24, the patient complained to the Practice of having a nose that “*streamed for three days*”. The

¹² Beclomethasone nasal (nose) spray is used to treat cold-like symptoms caused by allergic rhinitis. This is swelling of the inside of your nose.

IPA advised the Practice's prescription of this medication for the Patient was "*appropriate*". I accept that advice and consider the Practice met the relevant GMC standard.

37. I note NG120 states a clinician should "*not offer*" an antibiotic in the case of a patient who has "*an upper respiratory tract infection*" and who is "*not systemically very unwell*". I also note the PHA guidance on antibiotics advises "*many common infections are mild and will clear up without any treatment*". It also advises against the "*unnecessary use of antibiotics*" as this will "*slow down the development of antibiotic resistance*". The IPA advised the presenting signs and symptoms of the patient "*did not warrant an antibiotic*". I accept that advice.
38. The GMC guidance states a clinician must provide effective treatments based on the "*available evidence*". I have no reason to doubt the complainant's assessment of the patient's symptoms. However, the patient's records demonstrate that the patient reported different symptoms to the Practice. It is clear from records the condition of the patient deteriorated rapidly within two days following her consultation with the Practice. The IPA advised a URTI "*can*" turn into pneumonia although there is "*no*" definitive answer to the chances of that occurring. Nidirect guidance on pneumonia states the symptoms of pneumonia can develop "*suddenly (over 24 to 48 hours)*". Based on the evidence available, I am satisfied the Practice provided appropriate care and treatment to the patient during the consultation on 29 December 2022. I do not uphold this element of the complaint.

Follow up actions taken subsequent to the consultation

Detail of complaint

39. The complainant said the Practice "*did not follow up or contact [the patient] after the initial appointment*" in relation to "*the results of these blood tests or for*

any other reason". He also said the provision of safety-netting¹³ advice to patients "*puts responsibility back to the patient*".

Evidence Considered

Legislation/Policies/Guidance

40. I considered the following guidance:

- MDU Journal
- GMC Guidance
- BMJ Safety Netting article

The Practice's response to investigation enquiries

41. The Practice said the patient presented with symptoms of an upper respiratory tract infection. It did not consider the infection "*acutely medically concerning*" and "*it would not be common practice for a GP to arrange direct follow up with a patient presenting with an upper respiratory infection.*"

42. It recognised the patient's symptoms "*had been ongoing for eight days*". Therefore, the GP "*decided to arrange some follow up blood tests to look for any underlying causes such as diabetes*".

43. It advised the patient that "*conditions can deteriorate quickly*", and if she did deteriorate or feel worse, "*she would require to be reassessed by a GP or indeed A&E [the Emergency Department]*".

44. It advised the patient to contact the Practice herself "*in a week*" for the blood results. However, the Practice might contact her sooner "*if there is anything concerning*". It attempted to phone the patient on 3 January 2023 and left a voicemail message. It was only at this point the Practice checked the Northern Ireland Electronic Care Record¹⁴ and saw the patient was then a hospital in-patient.

¹³ Process of giving information to the patient about actions to take if their condition fails to improve.

¹⁴ A computer system allowing health and social care staff to access information about a patient's medical history.

45. It has since changed protocol and now *“provide patients with written safety advice which could be referred to if their condition deteriorates, and also shared with family members”*.

Relevant Practice and medical records

46. I considered the patient’s medical records for the period of December 2022 and January 2023. I also considered the notes provided by the Health & Social Care Trust in relation to the testing of the blood sample of the patient.

Relevant Independent Professional Advice

47. I enclose the IPA advice received at Appendix two to this report.

Analysis and Findings

48. The complainant said the Practice did not arrange follow up contact with the patient over the *“two full working days before the [Christmas] holiday weekend”*. This was despite its concern that the patient *“may have presented in the early stages of an evolving underlying condition.”*
49. In its response, the Practice said it is not *“common practice”* to follow up with patients diagnosed with an upper respiratory tract infection. The IPA advised it is *“totally impractical”* to follow-up on cases such as this as *“90%+ of patients improve”*. Otherwise, there would not be *“enough time in the day to see new cases”*. I accept that advice.
50. The IPA advised that instead, GPs provide safety-netting advice, which the Practice did. The BMJ Safety Netting article states *“illness is a dynamic process, and patients may present at any time point, including at a very early stage when it can be difficult to distinguish between a serious and self-limiting illness”*. The MDU Journal states *“safety netting involves ensuring that systems*

are in place to provide safe monitoring and follow-up". While I appreciate the complainant's view this approach places the responsibility back onto patients, I am satisfied the Practice acted in accordance with this guidance.

51. The complainant also said the Practice did not "*update*" the patient about the results of the blood test. He queried the Practice's response that it attempted to do so on 3 January 2023. The Practice provided my office with records evidencing it called the listed mobile telephone number of the patient at 12:29 on 3 January 2023. An accompanying note, time stamped at 12:30, documented it as a "*failed encounter*" and "*message left on answer machine*". The Practice said it was at this point it checked records and saw the patient was then an in-patient in hospital.
52. Based on the available evidence, I have not identified a failure in the Practice's care and treatment of the patient. I do not uphold this element of the complaint.

CONCLUSION

53. I received a complaint about care and treatment the Practice provided to the patient on 29 December 2022, and subsequent follow-up to that treatment.
54. Based on my consideration of all the evidence available, I did not identify any failure in the Practice's care and treatment of the patient. I do not uphold the complaint.
55. I acknowledge how distressing the patient's death was for the family, especially as she had been such a fit and active individual who led a healthy lifestyle. I also acknowledge the sense of loss felt by her husband and two daughters. I hope this report addresses the complainant's concerns and goes some way towards reassuring him that the Practice's efforts to treat the patient were reasonable and appropriate. I extend my deepest sympathies to the family for the loss of the patient.

Margaret Kelly

December 2024

NI Public Services Ombudsman

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and relevant guidance, 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.

