Man dies after GP admits not knowing pulmonary embolism could cause heart failure

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By Daniel Pye

A GP was unaware that a pulmonary embolism could cause heart failure when reviewing a patient's worrying blood test results the day before he died at home, an inquest has heard.

Dr Mark Ryan Foster, a 53-year-old university researcher, died on 17 February 2024 in Cockermouth, Cumbria from a pulmonary embolism.

A coroner found that Castlegate and Derwent Surgery failed to provide "basic medical care" by not admitting him to hospital, contributing to his death.

Foster had been experiencing breathlessness since December 2023 despite being usually fit and well.

A chest X-ray in January was unremarkable, but symptoms persisted. During a face-to-face consultation on 12 February, a trainee GP ordered a D-Dimer test to rule out pulmonary embolism, but it was not carried out that day.

When Foster attended an appointment with a practice nurse on 14 February, blood tests were requested but not a D-Dimer. By the time of the appointment, bloods would not be sent to the laboratory until the following day.

The coroner said that Foster not being seen by a GP on 14 February was a “missed opportunity”.

“It was accepted that the practice nurse, although experienced, was acting outside her normal practice. However, it could not be determined that this missed opportunity met the legal threshold for causation,” she added.

The blood tests revealed that Foster had a N-terminal pro b-type natriuretic peptide (proBNP) of 1981. A level above 1000 is "very rare", the coroner stated, and a raised BNP is "a sign of heart failure".

During a telephone consultation on 16 February to discuss these results, the GP was not aware that a pulmonary embolism could cause heart failure, a prevention of future deaths report (POFD) noted. The patient was referred for an outpatient echocardiogram with a waiting time of around 4–6 weeks.

The following day he collapsed at home and died despite resuscitation attempts. His post-mortem showed an occlusive thromboembolus in the right pulmonary artery. According to the report, expert opinion was that the onset of the pulmonary embolism was around 1 February.

"I found that there were missed opportunities to see Ryan in person and to refer him to hospital on 16 February 2024," Gomersal stated.

During the inquest she heard evidence from expert witnesses suggesting the chest x-ray and blood tests had excluded most causes of breathlessness, and Foster's 1981 pro-BNP was worrying. "Referral to secondary care was definitely required such that it was mandatory," she added. "The referral for an outpatient echo was not appropriate.

"Had Ryan been admitted to hospital, on the balance of probabilities, he would have survived."

Since the patient's death, the inquest heard that Castlegate and Derwent Surgery had taken steps including training on pulmonary embolism, reducing the number of trainees, increasing face-to-face consultations and clarifying the process for requesting blood tests.

However, it also heard evidence the practice was in a "state of turmoil" undermining leadership and safety.

The practice's investigation into Foster's death had not been fully completed and it does not "have a cogent method" of investigating incidents, Gomersal wrote.

"In my opinion action should be taken to prevent future deaths," she said.

Practice manager Claire Raven said staff are "deeply saddened" and acknowledge the care "did not meet the high standards of care that we strive to deliver".

The surgery has taken the coroner's findings "extremely seriously" and is reviewing its systems and governance structures, she added.

"Patient safety and quality of care remain our highest priorities, and we are determined to do everything possible to prevent a similar event from happening again," she said.