SPSO decision report

Case: **202101338, Lothian NHS Board - Acute Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment provided to their late adult child (A). A had been admitted to hospital from police custody due to cellulitis in their hand. A was monitored overnight and discharged the following day. A was readmitted several days later following a cardiac arrest. On resuscitation, a cannula (a tube that can be inserted into the body, often for the delivery or removal of fluid or for the gathering of samples) was found in A's arm dated the day of their initial admission. A's condition deteriorated and they died a few days later.

C was concerned that A's mental health issues were not taken into consideration and that it had been unreasonable to discharge A without these being assessed. C also believed it was unacceptable for A to have been discharged with a cannula in place given A's known drug misuse. C believed that these failings led directly to A's death as they had used the cannula to administer drugs immediately before suffering a cardiac arrest.

The board had carried out an Adverse Event Review (AER) following C's complaint. This found a number of failings in A's care. It made recommendations to try and address these.

We took independent medical advice from a consultant in emergency medicine. We found that there had been a full investigation of the case. The key learning points had been identified and actions were being taken to reduce the likelihood of a similar incident occurring in future. There was no evidence of failings which had not been addressed by the AER.

We upheld C's complaints due to the acknowledged failings in A's care.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings in the care and treatment, and discharge processes, in relation to A's admission to hospital. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.