SPSO decision report

Case: **202403985, Lothian NHS Board - Acute Services Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: not upheld, no recommendations

Summary

C complained about the care and treatment provided to their late sibling (A) when they were admitted to A&E, and about the boards out of hours (OOH) service. A was found to have Influenza A and signs of a chest infection. A deteriorated throughout the admission to A&E with increased oxygen requirements and coughing up blood. They then had a cardiac arrest and continued to deteriorate, suffering multiple organ failure. Attempts to stabilise A failed, and A died in hospital. C also complained about the family being pressured to decide whether to have a post-mortem and that a Significant Adverse Event Review (SAER) was not carried out.

The board acknowledged failings around appropriately regular observations not taking place whilst A was in hospital. However, they concluded that the overall care and treatment was reasonable given the circumstances at the time. In addition to this, the board did not uphold C's complaints regarding the OOH service, the post-mortem, and the SAER.

In respect of the care and treatment provided by the OOH service, we took independent advice from a GP adviser. We found that it was appropriate for a nurse practitioner to review A at the second of two OOH consultations the day before A was admitted to hospital. We found that the assessments and clinical decision-making, based on A's presentation at the time, were reasonable. We did not uphold this complaint.

In respect of the care and treatment provided when A was in hospital, we took independent advice from a consultant in emergency medicine. We found that appropriate regular observations did not take place. However, we considered that the overall care and treatment provided was reasonable, appropriate tests were carried out and appropriate treatment was provided, given A's presentation at the time. As such, we did not uphold this complaint.

In respect of whether the family was pressured into making a decision regarding a post-mortem, we found that communication with the family about a post-mortem was reasonable. We considered that we could not know for certain whether the consultant's notes were an accurate reflection of the discussion, due to the fact that people can have different perceptions of the same conversation. Given this, we did not uphold this complaint.

In respect of whether the board unreasonably failed to carry out a SAER, we found that, although A's death met the category 1 criteria for a SAER, we noted that health boards have discretion to decide what level of review is appropriate under the Healthcare Improvement Scotland guidance. We felt that the board could have improved their explanation of why they decided not to carry out a SAER and provided feedback around the importance of documenting the decision-making behind whether or not a SAER should be carried out. We concluded that it was not unreasonable for the board not to carry out a SAER. Therefore, we did not uphold this complaint.