SCOTTISH PUBLIC SERVICES OMBUDSMAN

People Centred | Improvement Focused

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: Mid Scotland and Fife

Case ref: 201803897, Fife NHS Board
Sector: Health
Subject: Hospitals / Clinical treatment / diagnosis

Summary

Mrs C complained about the care and treatment her mother (Mrs A) received at Victoria Hospital. Mrs A was admitted to hospital with a suspected infection in her leg, but died shortly afterwards. Mrs C said that the Board gave contradictory and incomplete replies to her questions about Mrs A's treatment. In particular, Mrs C believed that Mrs A's existing longstanding health condition, medications and associated immunosuppression had not been properly taken into account during her treatment. Mrs C was also concerned that medical staff did not communicate reasonably with the family during Mrs A's admission, which meant Mrs A's death had been unexpected and traumatic. Mrs C noted that the Board had failed to respond comprehensively to the questions she had asked, despite multiple meetings with staff, and a protracted correspondence. Finally, Mrs C said that Mrs A's death certificate contained errors, and that the Board had not made an adequate effort to correct these.

We took independent medical advice from a consultant in acute medicine. We found that there were significant failings on the part of the Board. The advice noted that there was no record that the most significant drugs Mrs A was receiving were identified by medical staff or taken into account in her treatment. In addition, although Mrs A had received initial treatment with antibiotics, this had been stopped and there was no detail or reasoning for this recorded in Mrs A's medical records. Following Mrs A death, the Board did not appear to have properly followed its own procedures for reviewing incidents where a patient had come to harm. We considered that Mrs A did not receive a reasonable standard of care and treatment and upheld this aspect of Mrs C's complaint.

We also found that the Board had failed to take reasonable steps to ensure Mrs A's death certificate was accurate. This included a failure to attempt to correct the death certificate. We upheld this aspect of Mrs C's complaint.

In relation to communication with the family, we did not uphold this aspect of Mrs C's complaint. Although we recognised that the family had found Mrs A's deterioration

distressing, the standard of communication between medical staff and the family was reasonable.

Finally, we found that the Board failed to handle Mrs C's complaint reasonably and upheld this aspect of her complaint.

Redress and Recommendations

The Ombudsman's recommendations are set out below:

What we are asking the Board to do for Mrs C:

Complaint number	What we found	What the organisation should do	What we need to see
(a), (b) and (d)	The Board failed to provide reasonable care and treatment to Mrs A, the Board failed to provide an accurate death certificate for Mrs A and the Board failed to handle Mrs C's complaint reasonably	Apologise to Mrs C for the failures identified in the report. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets	A copy of the apology. By: 19 February 2020
(b)	The Board failed to issue an accurate death certificate for Mrs A	Issue an accurate Form 11 (new medical certificate of death), so that the family can provide this to the Vital Events Team at the National Records of Scotland	A copy of the Form 11, with evidence it has been provided to the family By: 5 February 2020

We are asking the Board to improve the way they do things:

Complaint number	What we found	Outcome needed	What we need to see
(a)	The Board appeared to have failed to follow their own guidance on reporting on adverse incidents and holding SAERs	Review this case in light of the relevant guidance on SAERs, to determine why this was not followed	A copy of the review By: 19 February 2020
(a)	The Board had failed to resolve the questions over staff access to medical records and the decision to stop antibiotic therapy for Mrs A	Staff should have access to medical records and other patient information to ensure that treatment takes account of appropriate information at the appropriate time. Decisions about care and treatment should be clearly and accurately documented	Evidence of a SAER into Mrs A's care and treatment. This should include whether Mrs A's rheumatology records were accessed by medical staff and investigate whether staff were able to access rheumatology records. It should also review the decision to stop Mrs A's antibiotics, to establish why this decision was taken. A copy of the review report should be provided, including any action plans put in place as a result of it By: 22 April 2020

Complaint number	What we found	Outcome needed	What we need to see
(b)	The Board failed to issue an accurate death certificate for Mrs A	The Board should have adequate systems in place to ensure that death certificates are accurate when issued	The Board should demonstrate they have reflected on the mistakes made in Mrs A's case and report any resulting changes to processes for completing and issuing death certificates By: 4 March 2020

We are asking the Board to **improve their complaints handling**:

Complaint number	What we found	Outcome needed	What we need to see
(d)	We found the Board's complaint investigation had not answered all the questions raised by Mrs C and had failed to identify and address significant failings on the part of the Board	The Board should ensure complaint investigations conform to the NHS model complaints handling procedures, particularly in relation to time scales. It should ensure that all the issues raised by complainants are addressed, or explain clearly why it is not appropriate to do so	Evidence that the Board have reviewed the complaint investigation and established why it failed to respond to all the questions raised, or identify significant failures on the part of the Board. This should include the actions the Board intends to take to improve its complaint handling By: 4 March 2020

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils, housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Our service is independent, impartial and free. We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland.

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002, and this report is published in terms of section 15(1) of the Act. The Act says that, generally, reports of investigations should not name or identify individuals, so in the report the complainant is referred to as Mrs C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. Mrs C complained to me about the care and treatment provided to her mother (Mrs A). The complaints from Mrs C I have investigated are that:

a) the Board failed to provide Mrs A with reasonable care and treatment following her admission on 15 February 2018 (*upheld*);

b) the Board have failed to ensure Mrs A's death certificate was accurate (*upheld*);

c) the Board failed to communicate with Mrs C and her family reasonably during Mrs A's admission (*not upheld*); and

d) the Board failed to handle Mrs C 's complaint reasonably (*upheld*).

Investigation

2. In order to investigate Mrs C's complaint, my complaints reviewer made additional enquiries of the Board, and took advice from a consultant in acute medicine (the Adviser). In this case, I have decided to issue a public report on Mrs C's complaint because the investigation identified failings on the part of the Board, which resulted in a significant injustice to Mrs A and her family as well as significant learning points of a wider public interest.

3. This report includes the information that is required for me to explain the reasons for my decision on this case. Please note, I have not included every detail of the information considered. My complaints reviewer has reviewed all of the information provided during the course of the investigation. Mrs C and the Board were given an opportunity to comment on a draft of this report.

Background

4. This section contains a summarised chronology of Mrs A's admission to hospital, which is the subject of Mrs C's complaint.

5. Mrs A had a number of significant health problems including lupus and a long standing disease of the liver and gall bladder. She was referred by her GP to Victoria Hospital (the Hospital) in Kirkcaldy on 15 February 2018 with a painful swollen leg.

6. Mrs A was admitted at 15:30 on 15 February 2018 with a working diagnosis of cellulitis. Her need for prednisolone, a steroid Mrs A received regularly, was documented and she was prescribed it on admission.

7. At 17:03, Mrs A's venous glucose result was phoned through to the Admissions Unit and Mrs A was found to be significantly hypoglycaemic (low blood sugar levels); this was treated with intravenous glucose.

8. Mrs A was reviewed at 17:30 by the on-call Consultant (Doctor 1), who agreed with the diagnosis of cellulitis. An orthopaedic review was requested and at 17:30 Mrs A was discussed with the on-call orthopaedic doctor. At 17:50 Mrs A was given an antibiotic (flucloxacillin).

9. At 23:30, Mrs A was transferred to Ward 44.

10. On the morning of 16 February 2018 Mrs A received a further dose of antibiotic at 08:00. She was reviewed by a different Consultant (Doctor 2) during the ward round that morning. Mrs A was noted to be drowsy. Doctor 2 was not aware that Mrs A had been suffering from low blood sugar levels at the time of her admission and Mrs A's drowsiness was thought to be due to the morphine that she had been given to manage her pain. Mrs A's blood pressure was recorded as satisfactory and she was noted to be able to converse once roused. Her leg was very swollen and an urgent ultrasound was requested to exclude possible deep vein thrombosis (a blood clot in a vein).

11. At 16:00 on 16 February 2018, the note from the admission referring to Mrs A's low blood sugar was discovered by a junior doctor. Doctor 2 was called to review Mrs A and she was found to be drowsy with a very low blood sugar level. At this point, Mrs A's condition had deteriorated significantly.

12. Mrs A was recorded as suffering from low blood pressure, low BM (an abbreviation commonly used to refer to blood glucose levels), decreased consciousness, and metabolic acidosis body with a high lactate reading (an excess production of acid by the body with a build-up of lactic acid).

13. Mrs A was transferred to the High Dependency Unit (HDU). Medical staff noted she appeared to have deteriorated quickly and unexpectedly and was treated for low blood pressure and low blood sugar. Mrs A was reviewed by the intensive care team, who felt that there was nothing further that could be offered to her by way of medical treatment and that there would be no benefit to Mrs A from transferring her into intensive care.

14. At 18:00 a member of the medical team spoke with Mrs A's husband and then with Mrs A's husband and one of her daughters. They were informed Mrs A's death was imminent.

15. At 20:05, treatment was withdrawn from Mrs A. Mrs A's death was confirmed at 23:24 on 16 February 2018, a little over 32 hours from admission. A retrospective amendment to the medical records noted that Mrs A's death occurred at 20:40; no explanation was given for this amendment in the medical records. Mrs A's Cause of Death form recorded cerebellar lupus (an autoimmune disease) as the disease leading to death, and systemic lupus erythematosus, with primary biliary cirrhosis as a significant condition contributing to death but not related to the disease causing it.

Correspondence with the Board and the complaint process

16. I have set out the contact Mrs C had with the Board following Mrs A's death, along with the complaints correspondence in some detail. Although the information is known to all parties, a significant part of Mrs C's concerns relate to her view that the Board's responses have been either incomplete, or contradictory. Consequently, the correspondence has been set out in greater detail than usual.

17. Mrs C had concerns about Mrs A's care and treatment and met with the Board on 29 March 2018. Mrs C emailed the Board on 30 March 2018 setting out some further concerns. Mrs C's concerns at this point were that she had not been informed that Mrs A's liver was failing and she asked if this should have been identified sooner. This was based on her initial discussion with the Board on 29 March 2018.

18. The Board wrote to Mrs C on 20 April 2018. The letter was not part of their formal complaints process. The letter was sent from the Board's Clinical Director. It noted the various meetings Mrs C had had following Mrs A's death, including with the consultant responsible for Mrs A's rheumatology treatment (Doctor 3). Doctor 3 had not been involved in Mrs A's care and treatment during her final admission.

19. The Board told Mrs C that Mrs A's case notes had been reviewed by Doctor 2 and Doctor 3. They believed an atypical presentation of infection was the trigger for Mrs A's admission to hospital. Mrs A did not have a fever, due to the prednisolone she had been prescribed, so severe sepsis was not initially suspected. As her CRP[1] was high Mrs A had been investigated for cellulitis and given antibiotics to address this. As Mrs A's condition worsened she was moved to HDU for closer monitoring.

20. The letter set out Mrs A's test results, which were believed to show sepsis, and the Board said they believed the cause of Mrs A's death was multi-organ failure

[1] C-Reactive Protein, the level of which is used to diagnose levels of inflammation and as a marker of infection.

caused by sepsis. Mrs A's risk factors for sepsis were the immunosuppressive therapy necessary to control her cerebral lupus and systemic lupus erythematosus.

21. The Board said medical staff were not aware of the drugs prescribed by the rheumatologists and did not, therefore, know the degree of immunosuppression Mrs A was receiving. The Board said they would investigate how they could ensure drug information was available to clinical staff in future.

22. The Board said Doctor 2 did not believe Mrs A died of liver failure. There had been slight jaundice, which was common in patients with sepsis, particularly when there was an existing liver condition. They said this was not the cause of Mrs A's death.

23. The Board said they were sorry ward staff were not able to inform Mrs C sooner that Mrs A was close to death, so Mrs A's family were not able to spend more time with her. The Board added that the transfer of Mrs A to the HDU indicated staff were very concerned about her condition.

24. Mrs C then wrote to the Board on 14 May 2018. She said the letter from the Board of 20 April 2018 had raised more concerns for the family.

25. Mrs C was particularly concerned about the statement that medical staff were not aware of Mrs A's level of immunosuppression and the medication she had been receiving. Mrs C asked the Board to clarify what information had been available to medical staff. She noted it was unclear from the letter whether medical staff did not know Mrs A was receiving steroids, or whether they did know, but had failed to take it into account when making their diagnosis.

26. Mrs C also noted that it was unclear when medical staff had become aware of the medication Mrs A had been receiving as part of her rheumatology treatment. These drugs included cyclophosphamide and rituximab, which meant she was heavily immunosuppressed. Mrs C noted her father had been present at Mrs A's admission, but had not been asked about her existing conditions or what medication she had been receiving. Mrs C added Mrs A's medication had also been brought in, but had not been reviewed by medical staff at any stage.

27. Mrs C felt it was unclear from the Board's response if Mrs A's medical treatment would have changed had staff been aware of Mrs A's medication. Mrs C said her understanding was that individuals with weakened immune systems were particularly at risk from sepsis and she suggested that sepsis should have been considered much earlier, given the appearance of Mrs A's leg, and her immunosuppressed state.

28. Mrs C asked the Board for a timeline of Mrs A's treatment, including details of which staff had made decisions about her treatment. Mrs C also asked for the rationale for taking Mrs A off antibiotics. Mrs C said when this treatment was stopped on 15 February 2018, Mrs A did not receive any further medication to combat her infection that she was aware of. Mrs C also requested a more detailed explanation for the failure to identify Mrs A's low blood sugar earlier following her transfer to a ward.

29. Mrs C said her concern was that Mrs A's illness had not been recognised or treated early enough. Mrs C observed that Mrs A's transfer to HDU had not taken place until she was significantly unwell.

30. Mrs C also noted that the Board had not clarified if they intended to contact the Registrar's office about the errors on Mrs A's death certificate. Mrs C said the death certificate contained errors about the cause of Mrs A's death, and her underlying health conditions. She noted that every point listed in the Cause of Death form for Mrs A contained an error.

31. The complaint was acknowledged on 17 May 2018.

32. The Board responded on 17 July 2018. The letter contained a chronology of Mrs A's treatment. They noted the protocols for monitoring blood sugar levels had been changed and that all patients would have their levels checked on arrival in the ward. The Board said they believed it was difficult to know if an earlier diagnosis of sepsis would have changed the outcome for Mrs A.

33. The Board said following Mrs A's death, Doctor 2 met with the family on 21 February 2018 to discuss the events leading up to the diagnosis of severe sepsis and sent a copy of the death summary to Mrs C and Mrs A's GP. Doctor 2 offered to correct inaccuracies on Mrs A's death certificate prior to registering the death and offered a hospital post-mortem. Both these offers were declined.

(a) The Board failed to provide Mrs A with reasonable care and treatment following her admission on 15 February 2018

Concerns raised by Mrs C

34. Mrs C was concerned that Mrs A's frailty and co-morbidities were not properly taken into account when treating her. Mrs C said Mrs A was significantly immunosuppressed and very vulnerable to infection. Mrs C felt that Mrs A was not provided with proper antibiotic therapy and that not enough account was taken of her immunosuppressed state.

35. Mrs C said that if staff had diagnosed Mrs A with cellulitis, they should have known there was a risk of sepsis, due to Mrs A's immunosuppression. Mrs C said that in a letter to Mrs A's GP, immediately after her death, the Board had said that Mrs A was treated for 'possible cellulitis'. Mrs C noted subsequently that the language used by the Board became much more definite about Mrs A's diagnosis.

36. Mrs C said it appeared to be the case that only one course of antibiotics was given to Mrs A and asked why more antibiotics were not given if Mrs A was believed to be suffering from cellulitis. Mrs C was concerned that the Board had never explained the decision taken to stop antibiotic treatment or the factors that were taken into account when this decision was made.

37. Mrs C also noted the family were not informed at any point during Mrs A's admission that she was suffering from sepsis. Mrs C said it was first mentioned as a possibility to them, when they met with Board staff on 21 February 2018. Mrs C said the final response to her complaint suggested staff were certain during her admission that Mrs A had sepsis, but no explanation had been provided of how Mrs A was treated for this condition. Mrs C said she had thought Mrs A could have had sepsis when she saw her on 15 February 2018.

38. Mrs C said she remained unclear if staff treating Mrs A were aware of her medications and the effect these had on her immune system. Mrs C said the Board had never explained which staff were unaware of the drugs Mrs A had already been prescribed by rheumatology.

39. Mrs C noted the final response to her complaint stated Mrs A's prednisolone was recorded in her records and prescribed, and that staff knew Mrs A was taking steroids. Mrs C pointed out it was not clear if this information was taken into account by staff when treating Mrs A. Mrs C also felt this contradicted the statement in the Board's letter of 20 April 2018 that they did not suspect sepsis, because Mrs A had not been suffering from a fever on admission as her symptoms had been masked by the prednisolone Mrs A had been taking. Mrs C said either staff were aware of the risk factors associated with the medications Mrs A had been receiving, or they were not.

40. Mrs C said it had never been explained at what point precisely Doctor 2 had discovered Mrs A had been prescribed cyclophosphamide and rituximab. Mrs C pointed out that the Board, when providing the response of the medical staff who had cared for Mrs A, had stated they did not have access to information about the drugs Mrs A was prescribed by rheumatology.

41. Mrs C felt that despite the questions raised in her complaint, the Board had not said whether staff would have acted differently if they had been aware of the extent of Mrs A's immunosuppression from the outset. They had also failed to confirm if Mrs A's medical records were available to all staff when Mrs A was admitted.

The Board's response

42. The Board initially told my Complaints Reviewer that they had nothing further to add to the responses provided to Mrs C's complaint.

43. After further enquiries, the Board provided evidence in the form of new admission paperwork, showing changes to the monitoring of blood sugar on ward admission, to ensure that blood glucose levels were pro-actively recorded on transfer.

44. In response to my Complaints Reviewer's questions about the awareness medical staff had of Mrs A's immunosuppressed condition the Board provided a copy of a letter from the Rheumatology Department, which gave details of Mrs A's treatment. The Board said this had been accessed by staff on Mrs A's admission, although no evidence was provided to support this statement.

45. They also included a copy of the manuscript entry in Mrs A's notes from 16 February 2018, which they said showed Doctor 2 had been aware of Mrs A's immunosuppressed condition.

Medical advice

46. I asked the Adviser to assess whether Mrs A was provided with a reasonable standard of medical care following her admission. I have summarised the Adviser's views as follows.

47. Cellulitis was the working diagnosis on admission and when considering an infection like cellulitis, particularly in a patient who is immunosuppressed, the possibility of sepsis should also be considered.

48. The admitting doctor did not seem fully aware of the extent of Mrs A's immunosuppression due to her medication. The GP letter mentioned some of the medications Mrs A was receiving, but not them all. This was a significant failing on the part of medical staff. It was very concerning that information regarding medicines as powerful as those which Mrs A was receiving was not immediately available to doctors in another area of the healthcare system.

49. The computer generated list of medication from the GP did not mention prednisolone, it was hand written on the letter from the GP and having gone through the notes extensively, the Adviser was not able to find evidence that Mrs A was specifically identified as receiving rituximab or cyclophosphamide as part of her rheumatology treatment.

50. It was a significant failure on the part of the Board that medication information was not easily accessible. The Adviser thought that, had it been clear Mrs A was on powerful immunosuppressing medication, concerns about sepsis might have been raised earlier.

51. The Adviser noted the Board had stated that information regarding Mrs A's immunosuppression would probably have been available to admitting staff on the portal. The Adviser questioned why there was no record of the portal being accessed, or any record of the information that was obtained from there in Mrs A's notes. The Adviser also noted that it remained unclear from the Board's response if all staff had access to the portal.

52. The Adviser's view was that the additional information provided by the Board gave information from a range of sources about when Mrs A had received rituximab and cyclophosphamide. It had not clarified if this had been available to the admitting doctor, or considered as part of Mrs A's treatment.

53. In the Adviser's opinion, the level of Mrs A's immunosuppression should have meant medical staff were more wary of the possibility of severe infection or an atypical response to infection in her blood test results and her temperature. The Adviser's view was that if staff had been aware of Mrs A's levels of immunosuppression they would have been more aggressive in their treatment.

54. The Adviser noted there was a reference to hydroxychloroquine in Mrs A's notes. The note suggested medical staff were considering withholding this drug due to concerns about infection and its relatively weak immunosuppressive effects.

55. The Adviser said the more significant medication that Mrs A was receiving was the cyclophosphamide. This was not explicitly referred to in Mrs A's notes, and although the information was available in the portal, there was no evidence it had been accessed. Neither Doctor 1 nor Doctor 2 who reviewed Mrs A, documented that she was receiving cyclophosphamide or that she had previously received rituximab. The Adviser believed they would have done so in this situation had they been aware of this information. This suggested the portal could not be relied upon as a way of sharing information.

56. In terms of the reconciliation of Mrs A's medication at her admission, the Adviser noted that national guidelines recommended using two sources. In Mrs A's case these sources appeared to be the emergency care summary and the GP's letter. The Adviser said this was not unreasonable, but neither of these sources would include information about medication being given in secondary care, such as rheumatology.

57. The Adviser's view was that although it would have been preferable to speak to Mrs A's family as well, they may not have been aware of the significance of all the medication Mrs A was receiving. The Adviser said it was unreasonable for the Board's information sharing system to allow Mrs A to be admitted for treatment whilst receiving two potent immunosuppressive medications, without this information being accessed by the medical staff caring for her.

58. I also asked the Adviser if it could be ascertained from the available evidence whether Mrs A's level of immunosuppression was identified and taken into account in her treatment. The Adviser provided the following response.

59. The main failing was a failure to clarify what immunosuppression medication Mrs A was receiving. The fact that the medical clerking picks up hydroxychloroquine as a concern showed medical staff were considering the threat of immunosuppression.

60. If medical staff had been aware about rituximab or cyclophosphamide, the Adviser considered it would have been documented because medical staff had taken the time to query the hydroxychloroquine Mrs A was receiving. More information from the rheumatology team regarding her treatment would have been very helpful and should have been easy for the medical staff treating Mrs A to obtain.

61. The fact that the admitting team did not know about her receiving medications such as cyclophosphamide or rituximab was very concerning. The Adviser pointed out that the fact my Complaints Reviewer had to contact the board for more information regarding Mrs A's treatment shows how little evidence there was in the medical records of what the admitting team knew about Mrs A's rheumatology treatment. This needed to be addressed by the Board as a priority.

Mrs A's treatment with antibiotics

62. The Adviser was asked to review the decision to stop Mrs A's antibiotic therapy. The Adviser told me:

63. Flucloxacillin was a reasonable choice of antibiotic for cellulitis with the plan to review Mrs A if she did not improve. The immunosuppression should have made

medical staff consider a more powerful antibiotic when it became clear Mrs A was not responding to the flucloxacillin.

64. Mrs A received a further dose of antibiotic at 08:00 on 16 February 2018, but the antibiotics were stopped after this. Mrs A received no further antibiotics, even when she was deteriorating, being moved to HDU, receiving a CT head scan and other medications such as hydrocortisone (a steroid) and metaraminol (a drug used to treat low blood pressure).

65. The Adviser noted that further antibiotics might not have saved Mrs A's life when she had already begun to deteriorate. It should, however, have been one of the first actions to provide intravenous (IV) antibiotics in a possible sepsis case. It appeared from the medical records that sepsis was not considered as a cause of Mrs A's deterioration.

66. It was, in the Adviser's view, unreasonable for Mrs A's treatment with antibiotics to have been stopped. They noted that there was no detail or reasoning for this decision in Mrs A's medical records.

The effect of Mrs A's prednisolone on her treatment

67. Mrs C specifically raised concerns about the statement by the Board that this drug might have affected their ability to diagnose Mrs A with sepsis. The Adviser's comments on this area of Mrs A's treatment were as follows.

68. The prednisolone dose was accurately recorded, considered and documented in Mrs A's admission clerking. The clerking did not mention whether Mrs A had had that dose that morning, but given that Mrs A seemed relatively well when she first came in, the Adviser felt it was not unreasonable for medical staff to assume she had had her morning medication.

69. On such a high dose, immunosuppression should have been assumed and there should have been a more marked response to Mrs A's hypoglycaemia, including recognising that she may need more steroids or that these should be given in an alternative way. The Adviser noted that IV steroids were eventually given when Mrs A was more profoundly unwell.

70. The Adviser was of the view that the prednisolone was an issue during Mrs A's deterioration on 16 February 2018, but it was recognised and treated appropriately at that point.

(a) Decision

71. Mrs C felt the Board had failed to answer the questions she had raised about Mrs A's care and treatment. Mrs C continued to believe that Mrs A's care and treatment had been inadequate and that had it been better, Mrs A might have survived. The Board told my Complaints Reviewer they were satisfied their responses to Mrs C's complaints had addressed all her concerns.

72. I have to note at the outset, that the Board's responses to my office's enquiries were inadequate and did not address the questions we and Mrs C had raised.

73. The advice I have received and accept fully is that Mrs A's care fell below a reasonable standard due to some significant failings. The Board have not provided evidence which answers or refutes Mrs C's concerns and I am particularly critical of the contradictory statements made by the Board.

74. As noted previously, the Board wrote to Mrs C on 20 April 2018 stating unequivocally that medical staff were not aware of the immunosuppressive medication Mrs A had been prescribed by the rheumatology department. This is supported by the advice I have received which notes it would have been reasonable to expect the powerful medications Mrs A was receiving to have been recorded in her medical notes, along with evidence that they were considered as part of her treatment plan.

75. The Board subsequently said medical staff 'probably' had access to this information through accessing the portal system. The Board also referred my Complaints Reviewer to an entry in Mrs A's manuscript notes at 18:00 on 16 February 2018. This read:

> "I have d/w husband and one of 2 daughters. Explained that has continued to deteriorate over the course of the afternoon. Has had multiple immunosuppressive drugs for lupus but with no good longer term outcome. We have discussed with IT."

76. The Board suggested this showed that medical staff were aware of the level of Mrs A's immunosuppression and the medication she was receiving.

77. In my view, this does not provide evidence that Mrs A's medication and associated immunosuppression were taken into account from the point of her admission. The entry was made after Mrs A had deteriorated significantly, and her condition could no longer be treated. There is no explicit reference to the medication that Mrs A was receiving, and as set out in the advice received, this is not recorded

anywhere earlier in Mrs A's records. There is also no indication of what impact this information had on Mrs A's treatment plan, which would have been a reasonable expectation.

78. The Board's response to my Complaints Reviewer's enquiries has not explained why the doctors involved in Mrs A's care stated in April 2018 that medical staff were unaware of Mrs A's rheumatology medication.

79. I note in the Board's letter of 20 April 2018 that they promise they will investigate how they can ensure drug information is available to clinical staff. If it was the case, as was latterly suggested by the Board, that medical staff did access Mrs A's drug information, and were aware of the medication Mrs A was receiving, then there would have been no reason for the Board to have given this undertaking. The Board's responses have failed to explain this contradiction.

80. I must be clear that I have not found evidence that Mrs A would have survived had her treatment been different. There is no doubt, however, that the care and treatment she received fell well below a reasonable standard and there were significant failings in the way Mrs A's medication was assessed and in the decision to stop treating her with antibiotics. I am particularly critical that an early apparent acknowledgement of these failings was not followed up by the Board and of the Board's subsequent failure to respond to questions about this aspect of Mrs A's care.

81. I have also considered the Board's *Adverse Events Policy,* implemented in June 2013 and so in force at the time of Mrs A's treatment. The definition of an 'adverse event' is an event that could have caused or did result in harm to people or groups of people.

82. The policy refers to Category 1 events as

> **"Major or Extreme: Significant Adverse Events: Events which may have contributed or resulted in permanent harm,** for example death/life changing injury, intervention required to sustain life, severe financial loss (£>1m), ongoing national adverse publicity, likely to be graded as major or extreme"

83. Category 1 events require either a Local Adverse Event Review (LAER), or a Significant Adverse Event Review (SAER). Importantly, an Executive Panel is required to decide on the level of review.

84. Appendix 3a of the document provides a list of events which the Board state must be graded as major or extreme. This includes

"Medication incident – drug omitted, wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration, suspected adverse drug reactions."

85. In my view, Mrs A's case, an unexpected death from sepsis, with issues around the medication she was receiving, clearly fell under the Board's policy and should have been reported as an adverse incident. That it was not, represents a significant failure on the part of the Board.

86. I am critical that the Board did not follow its published policies. There is no evidence of Mrs A's case being reported as a possible adverse event, or of it being considered by an Executive Panel. It is also concerning that this was not identified by the Board's own complaint investigation. Again I note that the Adverse Events Policy provides for the possibility that a complaints investigation could identify an adverse event. This was, therefore, a second missed opportunity for the Board to identify and review the failings in Mrs A's care.

87. I would ask the Board to reflect on the impact that its failures have had on the family's relationship with the NHS. I would also ask them to reflect on the impact this has in particular on their trust in the Board and the weight that can be given to the Board's commitment to identifying and implementing learning from their experience.

88. I uphold this complaint.

(b) The Board have failed to ensure Mrs A's death certificate was accurate

Mrs C's concerns

89. Mrs C said the family had been particularly upset when they discovered that Mrs A's death certificate had contained a number of inaccuracies. Mrs C said the Board's claim that they had been offered the opportunity to change this, but had declined that offer, was inaccurate. Mrs C also noted that the Board had not addressed the issue of why the death certificate had been inaccurate.

90. Mrs C told my Complaints Reviewer that the death certificate was collected from the Hospital by a family member on Monday 19 February 2018. The doctor who handed it over said they had only been present at the point of death and could not discuss the details of Mrs A's care.

91. Mrs A's death was registered on 20 February 2018 and the family met Doctor 2 on 21 February 2018. Mrs C said they were unsure about all the information in the death certificate, but were busy arranging Mrs A's funeral and lacked the medical

knowledge to question the information on the death certificate. Mrs C said she was clear that no offer was made to correct or alter the death certificate at this point.

92. Mrs C pointed out, in support of her complaint, that it was not until 29 March 2018 when they met with Doctor 3 that the family had it confirmed that the death certificate was inaccurate. Mrs C said they had then raised their concerns, and received an email on 3 April 2018 saying enquiries would be made about changing the death certificate, but they had heard nothing more.

Medical advice

93. I asked the Adviser to assess the errors on Mrs A's death certificate, to see if there was a reasonable explanation for them and also to consider whether the Board's response had been appropriate. The Adviser's views were as follows.

94. It is important that the death certificate is as accurate as possible and some of the inaccuracies seemed odd to the Adviser. The reason for the errors having occurred could not, in the Adviser's view, be accurately determined from the available evidence.

95. Importantly the Adviser felt that the Board had failed to identify the appropriate learning from the mistakes. This was that that death certificates needed to be completed when staff had the time to review the medical records, and could ensure the certificate was as accurate as possible. It was correct, however, that a certificate could not be updated once it had been registered.

(b) Decision

96. It is not disputed that Mrs A's death certificate was inaccurate. The Board have not provided an explanation for these errors and the advice I have received is that it is not possible now to determine the exact cause of the inaccuracy, although in the absence of any other reasonable explanation, it seems likely human error was the main contributing factor.

97. Clearly it was a failure on the part of the Board to issue an inaccurate death certificate. They have stated that an offer was made to Mrs C to correct the inaccuracies prior to registration, but that this was declined. They have not provided any evidence to support this.

98. The Board's complaint investigation did not attempt to establish why the death certificate contained inaccuracies in the first place. I am also unclear why medical staff did not address the inaccuracies in the death certificate when they became

aware of them. It was, in my view, inappropriate to place responsibility for this decision on the family at a time when they were clearly very distressed.

99. I also note Mrs C strongly refuted the Board's suggestion that the family were given the opportunity to have the certificate corrected but declined it. The fact that the errors in the death certificate were not confirmed to the family until 29 March 2018 when Mrs C met with Doctor 3, supports this.

100. On balance, I am not persuaded by the Board's position that the family were offered the opportunity to have the death certificate amended, but chose not to do so. In particular, I note Mrs A's death had been registered by the family on 20 February 2018, and it would not have been possible for the death certificate to have been altered on 21 February 2018 when the Board state an offer was made by Doctor 2 to correct the certificate.

101. I further note that on 3 April 2018, the Board emailed the family saying they were happy to change the death certificate and were going to look into how this could be done. This also suggests that at this point, there had not been an offer to the family, as the Board make no reference to it.

102. Ultimately, there is no evidence to show Mrs A's family were offered and then rejected a chance to correct the inaccuracies on the death certificate registered for Mrs A. My view is that ultimately the responsibility for ensuring that the death certificate was accurate lay with the Board. Had they met this requirement, then there would be no discussion over whether Mrs C and her family were made an offer to correct these errors.

103. It was unreasonable for the Board to provide an inaccurate death certificate for Mrs A and to have then failed to provide clear advice on the procedure for amending it when inaccuracies were discovered.

104. I uphold this complaint.

(c) The Board failed to communicate with Mrs C and her family reasonably during Mrs A's admission

105. Mrs C felt the Board's communication with her and the family was inadequate in several areas. In particular, Mrs C said the family were not given a reasonable amount of information about Mrs A's condition. She said they were not told at any point Mrs A might have sepsis, or that this was suspected by the medical staff. They were not informed this had been considered as a possibility until 21 February 2018.

106. Mrs C had concerns about the failure of medical staff to discuss Mrs A's existing medical conditions with the family. Mrs C said this meant an opportunity was missed to give staff a full picture of Mrs A's health.

107. Mrs C said the family were not made aware how serious Mrs A's condition was. As a result, she was travelling to England the day after Mrs A's admission, but had cut the journey short, in order to return to the Hospital. Mrs C told us the family had believed Mrs A's death was largely due to liver failure caused by her long standing health conditions and that she had found it particularly distressing to learn that Mrs A had been suffering from sepsis, as Mrs C had suspected Mrs A was suffering from this during her admission.

The Board's response to my office's enquiries

108. As noted previously, the Board stated they had nothing to add to their response to Mrs C's complaints.

Medical advice obtained

109. The Adviser noted that Mrs A's deterioration on 16 February 2018 appeared to have been rapid. Mrs A had not been a cause for concern when she was reviewed during the morning ward round. By 16:00 Mrs A was clearly unwell. Family members were spoken to around this time. The Adviser's view was that the family were told about Mrs A's condition within a reasonable timeframe.

(c) Decision

110. Mrs C and her family felt they were not provided with adequate information about Mrs A's condition. As a result, her deterioration came as a great shock to them. They feel they were denied the opportunity to spend time with Mrs A during her final hours. Other family members were denied the opportunity to speak to her at all, as they could not reach the hospital in time.

111. It is important to note that any assessment of Mrs A's condition and the information passed to the family by staff can only be based on what was known at the time. Accordingly I have only considered the contemporaneous evidence about Mrs A's condition which would have been available to medical staff at the time.

112. The advice I have received and accepted is that there is no evidence staff were aware of Mrs A's deterioration earlier in her admission and that it would not have been possible for Mrs A's family to have been advised of this sooner than they were.

I do not find, therefore, that the standard of communication with the family was deficient in this regard.

113. I have also considered whether more information should have been sought from the family about Mrs A's medications when she was admitted to hospital. I note the advice I have received in this respect is that whilst it is useful to discuss a patient's medication with the family, it is not a requirement, provided that two sources of information are used for reconciliation of the medicines the patient was receiving.

114. I do not underestimate how shocking and traumatic it was for Mrs C and her family to learn that Mrs A had deteriorated so swiftly. However, the available evidence shows that Mrs A's deterioration was sudden and the family were informed at the earliest opportunity.

115. I do not uphold this complaint.

(d) The Board failed to handle Mrs C's complaint reasonably

Mrs C's concerns

116. Mrs C felt her complaint had not been handled appropriately. Mrs C said the Board had failed to answer all the specific questions she raised in her complaint. As a consequence, she and her family had been obliged to bring the case to my office.

117. Mrs C said they had no clarity over issues around Mrs A's immunosuppression, the antibiotic treatment she had received and what staff had and had not known about Mrs A's medical condition. Mrs C also noted the Board's response stated the family had been offered a corrected version of Mrs A's death certificate, but had declined it, which Mrs C denied.

118. Mrs C felt that the investigation into her complaint had taken too long and that the final response from the Board was inadequate.

(d) Decision

119. Mrs C's complaint took longer than the stated 20 working day period to be responded to. Mrs C was also concerned that despite several meetings and related correspondence with the Board, she still had unanswered questions.

120. Looking at the Board's correspondence and interactions with Mrs C, it appears that initially, her concerns were not treated as a formal complaint. The first letter she received on 20 April 2018 did not refer to the complaints process.

121. This letter raised a number of concerns for Mrs C, and she raised a detailed formal complaint as a result. Given that this letter was from the medical staff treating Mrs A, it is surprising and concerning that subsequent correspondence from the Board did not address clearly the issues Mrs C raised. Nor did it reference this first letter, particularly as it identified and acknowledged a clear failing on the part of the Board.

122. I consider it is unreasonable that the Board's complaint investigation produced a response which failed to answer the points raised by Mrs C. The Board's investigation should have addressed the statements made in the letter sent to Mrs C on 20 April 2018. If the Board considered that following its investigations that letter was inaccurate, then this should have been explained, and the commitment to further investigation should have been addressed.

123. As noted in the conclusions reached on the other complaints investigated by my office, Mrs C's complaints should have allowed the Board to identify significant failings. In particular, I am highly critical of the failure by the Board's investigation to address the issue of medical staff being able to access information about the medication prescribed to patients by specialist services in other clinical areas. Despite the initial response to Mrs C highlighting it, and it being raised by my Complaints Reviewer as an urgent concern during this investigation, the Board have failed to give any indication that action is being taken to address this.

124. The Board's complaint investigation also failed to consider the question of Mrs A's antibiotic treatment, which was explicitly raised by Mrs C. It did not attempt to establish how the errors in Mrs A's death certificate occurred, and the complaint response did not provide the family with a clear explanation of what steps were available when an incorrect death certificate had been registered.

125. Overall, the Board's complaint investigation and response was wholly inadequate. This compounded the significant injustice experienced by the family and I am concerned that such serious failings were not acknowledged and addressed by the Board.

126. It is also of concern to me that my office has previously issued a public report which was critical of the handling of complaints by the Board. In particular the report identified a failure by the Board to address the issues raised by the complainant when they issued their final response.

127. It is important that where failings are identified by this office, that the actions taken by the Board address these. In this case, Mrs C's complaint was received by

the Board around a month after they had provided evidence to my office that they had complied with the recommendations we made. I am, therefore, making more demanding recommendations of the Board to reflect the fact that this issue should have been addressed.

128. I uphold this complaint.

Recommendations

Learning from complaints

The Ombudsman expects all organisations to learn from complaints and the findings from this report should be shared throughout the organisation. The learning should be shared with those responsible for the operational delivery of the service as well as the relevant internal and external decision-makers who make up the governance arrangements for the organisation, for example elected members, audit or quality assurance committee or clinical governance team.

What we are asking the Board to do for Mrs C:

Complaint number	What we found	What the organisation should do	What we need to see
(a), (b) and (d)	The Board failed to provide reasonable care and treatment to Mrs A, the Board failed to provide an accurate death certificate for Mrs A and the Board failed to handle Mrs C 's complaint reasonably	Apologise to Mrs C for the failures identified in the report. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets	A copy of the apology. By: 19 February 2020

Complaint number	What we found	What the organisation should do	What we need to see
(b)	The Board failed to issue an accurate death certificate for Mrs A	Issue an accurate Form 11 (new medical certificate of death), so that the family can provide this to the Vital Events Team at the National Records of Scotland	A copy of the Form 11, with evidence it has been provided to the family By: 5 February 2020

We are asking the Board to improve the way they do things:

Complaint number	What we found	Outcome needed	What we need to see
(a)	The Board appeared to have failed to follow their own guidance on reporting on adverse incidents and holding SAERs	Review this case in light of the relevant guidance on SAERs, to determine why this was not followed	A copy of the review By: 19 February 2020
(a)	The Board had failed to resolve the questions over staff access to medical records and the decision to stop antibiotic therapy for Mrs A	Staff should have access to medical records and other patient information to ensure that treatment takes account of appropriate information at the appropriate time.	Evidence of a SAER into Mrs A's care and treatment. This should include whether Mrs A's rheumatology records were accessed by medical staff and

Complaint number	What we found	Outcome needed	What we need to see
		Decisions about care and treatment should be clearly and accurately documented	investigate whether staff were able to access rheumatology records. It should also review the decision to stop Mrs A's antibiotics, to establish why this decision was taken. A copy of the review report should be provided, including any action plans put in place as a result of it By: 22 April 2020
(b)	The Board failed to issue an accurate death certificate for Mrs A	The Board should have adequate systems in place to ensure that death certificates are accurate when issued	The Board should demonstrate they have reflected on the mistakes made in Mrs A's case and report any resulting changes to processes for completing and issuing death certificates By: 4 March 2020

We are asking the Board to **improve their complaints handling**:

Complaint number	What we found	Outcome needed	What we need to see
(d)	We found the Board's complaint investigation had not answered all the questions raised by Mrs C and had failed to identify and address significant failings on the part of the Board	The Board should ensure complaint investigations conform to the NHS model complaints handling procedures, particularly in relation to time scales. It should ensure that all the issues raised by complainants are addressed, or explain clearly why it is not appropriate to do so	Evidence that the Board have reviewed the complaint investigation and established why it failed to respond to all the questions raised, or identify significant failures on the part of the Board. This should include the actions the Board intends to take to improve its complaint handling By: 4 March 2020

Terms used in the report **Annex 1**

cellulitis	a potentially serious infection of the deeper layers of the skin
cyclophosphamide	a drug used to treat lupus
Doctor 1	the on-call consultant, who reviewed Mrs A at her admission
Doctor 2	the consultant responsible for Mrs A's care from 16 February 2018 onwards
Doctor 3	the consultant rheumatologist who oversaw treatment of Mrs A's long term health conditions. They were not involved in Mrs A's care during her final admission to hospital
flucloxacillin	an antibiotic
hydroxychloroquine	an immunosuppressant drug used in the treatment of lupus among other conditions
lupus	a long-term autoimmune disease
Mrs A	the complainant's mother, whose care and treatment was the subject of this investigation
Mrs C	the complainant
prednisolone	a steroid
rituximab	a drug used to treat lupus

sepsis	a potentially life-threatening condition caused by the body's response to an infection
the Adviser	a Consultant in acute medicine who provided an independent assessment of the case
the Board	Fife NHS Board
the Hospital	Victoria Hospital, Kirkcaldy