SPSO decision report

Case: **201103274, Lothian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: not upheld, recommendations

Summary

Mr C's late wife (Mrs C) was diagnosed with a thickened area of the womb due to complex hyperplasia (the result of the formation of extra cells) and was referred to a waiting list for a hysteroscopy, dilatation and curettage (a D&C - treatment to correct this). Mrs C had the operation as a day procedure. Mr C said that following the procedure and on discharge home that day, Mrs C became increasingly unwell. Two days after the procedure, he phoned the local medical practice GP for a home visit, and the GP arranged for Mrs C to go to hospital. Mrs C was taken to the intensive care unit where she died four days later. A post mortem was carried out and the death certificate stated the cause of death as septic shock (severe infection), intrauterine sepsis (a viral infection in the womb), acute renal (kidney) failure and cardiomegally (enlarged heart).

Neither the board nor the Procurator Fiscal's post-mortem could establish the reason for Mrs C's death. Mr C and his family complained to the board about this. The board investigated the case, held an internal review and met with Mr C, his family and an independent caseworker. Mr C believed that the board had a responsibility for his wife's death and had failed to provide an explanation for it. He also said the board failed to communicate with him and Mrs C and that there was a failure to act on nursing staff's concerns about Mrs C's discharge.

Our independent medical adviser considered all aspects of Mr C's complaints. Having taken account of his advice alongside the evidence provided by Mr C and the board, we concluded that there was no proof of the cause of Mrs C's infection. In the absence of such evidence, we found that the board had not in fact failed to provide Mr C with a reason for the cause of infection. We also carefully considered all aspects of the communication between the board, Mr C and Mrs C. There was no evidence to support the complaint of failure to communicate, or that the risks of the operation were not explained to Mrs C, and that Mr C had not been advised of the warning signs to observe on Mrs C's discharge. There was also no evidence that nursing staff had raised concerns about Mrs C before she was discharged. Although we did not uphold Mr C's complaints, we did make recommendations to address issues that had emerged during our investigation.

Recommendations

We recommended that the board:

- ensure that medical staff (and patients) legibly complete every section of a consent form at the time consent is obtained;
- ensure all staff complete a record or document outlining the information leaflets they provided to patients; and
- provide the Ombudsman with an update on their review of the written information provided.