SPSO decision report

Case: **201507779, Tayside NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Miss C's father (Mr A) attended his medical practice with urinary problems. Tests and investigations indicated prostate cancer had spread to his bones and Mr A was admitted to Ninewells Hospital. His condition deteriorated significantly due to sepsis (a life-threatening bacterial infection of the blood) and he died two days later. Miss C complained about clinical failings in relation to investigations and treatment decisions by nursing and medical staff, including that Mr A's deteriorating condition was not recognised within a reasonable timeframe.

We took independent advice from a nursing adviser, a specialist in urology and a specialist in nephrology (the study of the kidney). In relation to the standard of nursing care provided, including communication, we found that in the main this was reasonable. We therefore did not uphold this aspect of Miss C's complaint.

With regard to the medical care and treatment provided, we found that medical staff had unreasonably failed to recognise Mr A had been suffering from sepsis and that there had been an unacceptable delay in administering antibiotics. We were also critical that medical staff failed to investigate fully Mr A's kidney injury. We therefore upheld this aspect of Miss C's complaint. However, due to Mr A's limited life expectancy as a result of his cancer, we could not say what the outcome would have been had Mr A had been investigated in a reasonable manner and treated with antibiotics earlier. However, the failings identified meant that it was possible that an opportunity to extend Mr A's life had been missed.

Miss C also complained that the board failed to respond to her complaint within a reasonable timeframe. The board acknowledged this and apologised to Miss C. We therefore upheld this aspect of Miss C's complaint.

Recommendations

We recommended that the board:

- take action to ensure the failings in aftercare and support are addressed to ensure no recurrence;
- provide us with an action plan to address the failings highlighted in this investigation and ensure no recurrence; and
- apologise for the failings identified during this investigation.