SPSO decision report

Case: **201508281, Lothian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Ms C complained about the care and treatment given to her father (Mr A) at the Western General Hospital. Mr A, who had cirrhosis (scarring of the liver as a result of continual, long-term damage), deteriorating liver function and liver cancer, was admitted to the hospital for a head scan to investigate possible brain metastasis (a cancer that has spread from its primary site).

Ms C considered that staff gave Mr A inappropriate sedation, which rendered him unconscious, and failed to provide him with appropriate medication for alcohol withdrawal. Ms C believed this led to a sudden deterioration in Mr A's condition and his subsequent death in the hospital.

We took independent advice from a consultant physician experienced in the management of liver disease and cancer of the bile ducts. We found that parts of Mr A's care and treatment were reasonable, in particular that there was no undue delay in carrying out Mr A's head scan and that the palliative care given to Mr A was appropriate.

However, the adviser identified failings in relation to the sedation and medication given to Mr A, in the assessment of his alcohol dependency, and in treating his ongoing constipation. The adviser also considered there were shortcomings in parts of the board's alcohol withdrawal plan (AWP). However, the adviser concluded that despite the failings identified in Mr A's care and treatment, his death was not caused or hastened by these failings. We accepted this advice. Given that our investigation found failings in Mr A's care and treatment, we considered this to be unreasonable and upheld Ms C's complaint.

In the course of our investigation, the board told us they accepted there had been a lack of documentation relating to the sedation administered to Mr A, for which they had apologised.

Recommendations

We recommended that the board:

- apologise to Ms C and her family for the failings in Mr A's care and treatment;
- urgently review and update the AWP, taking account of the comments of the adviser and the relevant National Institute for Health and Care Excellence Guidelines, in relation to the sedation and medication given to patients and the use of validated scores for the assessment of alcohol dependency;
- ensure the comments of the adviser are shared with the relevant staff and acted upon; and
- provide evidence of the action taken to prevent a recurrence of the lack of documentation relating to the sedation administered to Mr A.