SPSO decision report

Case: **201907613, Lothian NHS Board - Acute Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment provided to their spouse (A). A suffered from progressive lung disease and required prostate surgery. There was a significant delay in performing A's surgery, during which time A's health deteriorated. A was discharged home following their operation, but was readmitted the following day and died shortly afterwards.

C believed that A would have survived had the operation been performed sooner, as their health would have been better. C also said that A's death certificate was inaccurate, as it stated that A had died from community acquired pneumonia. C said that A had not been well when they were discharged, had been at home for less than 24 hours and had spent the majority of that period in bed.

We took independent medical advice. We found that A's condition had not been properly monitored following their operation, as the board's assessment had been based on assumptions about A's condition prior to admission. This meant that A had been discharged without evidence of a deterioration in their condition being properly considered. We also noted that it was not possible to determine that A's pneumonia was 'community acquired'.

We considered that A's care and treatment had fallen below a reasonable standard. However, we noted that it is not possible to be certain what the outcome would have been had A been operated on sooner.

We also found that C's complaint had not been handled to a reasonable standard. The board had initially informed this office that it had nothing to add to its response to C's complaint. However, following our enquiries, the board accepted that it was unlikely that A had acquired pneumonia in the community. Additionally the board's complaint investigation had failed to identify that A's condition was not properly assessed prior to discharge.

We upheld both of C's complaints.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for failing to asses A's condition, incorrectly describing their pneumonia and issuing an inaccurate death certificate. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.
- Assist C with obtaining a corrected death certificate.

What we said should change to put things right in future:

- Medical staff should correlate information about a patient's condition on admission, such as oxygen saturation levels as part of the patient's assessment prior to discharge.
- The board should remind relevant medical staff that, when issuing a death certificate, careful consideration

needs to be given to ensuring it accurately reflects the cause of death.

In relation to complaints handling, we recommended:

- Complaint responses should respond to all of the points of complaint raised by a complainant.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.