SPSO decision report

Case: **202304229, Lanarkshire NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about the care and treatment provided to their late partner (A) who was admitted to hospital due to abdominal pain, severe lower back pain, weight loss and reduced appetite. A CT scan identified a left hepatic vein thrombosis (a blood clot in the vein draining the liver). A was commenced on anticoagulant (blood thinning) medication. A further CT scan showed that A had new thrombus in the portal vein (the main vein draining into the liver). Following discussion with haematology (specialists in conditions of the blood), A's anticoagulation medication was changed.

Several days later A complained of a headache and vomiting and was given pain medication. The following morning A was found to be unresponsive by nursing staff. Levetiracetam (an anticonvulsant medication) was administered and A was taken for a CT scan which showed extensive intracerebral haemorrhage (bleeding into the brain tissue). Protamine (medication that partially reverses the effects of the anticoagulation medication) was administered and advice sought from neurology (specialists in conditions of the nervous system) who said that on review of the scans, the extent of the bleeding was not survivable. A died shortly after.

C complained that the board unreasonably failed to warn A of the risks of anticoagulation medication and unreasonably administered protamine and levetiracetam shortly before A's death. C complained that the board unreasonably failed to include anticoagulation medication on the death certificate and failed to communicate to A's family that it was a cause of death.

We took independent advice from a consultant in acute medicine. We found that the use and timing of both levetiracetam and protamine was reasonable. We did not uphold this part of C's complaint. However, we found that the board failed to warn A of the risks of the anticoagulation medication before commencing the treatment. We also found that the board unreasonably failed to include the anticoagulation medication on the death certificate and failed to communicate that it was a cause of death to A's family. Therefore, we upheld these parts of A's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified. The apology should meet the standards set out inthe SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

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

- Patients prescribed anticoagulation medication should be given appropriate information on the risks and benefits of anticoagulants, in line with relevant clinical guidance and this should be clearly documented within the patient records.
- Relevant information about a patient's death should be effectively communicated to their family.

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.