



**Embargoed until 00:01BST Thursday 13 September 2018**

## **Avoidable death of woman after delayed diagnosis and poor management of sepsis**

### **Organisation we investigated**

Doncaster and Bassetlaw Hospitals NHS Foundation Trust

### **Date investigation closed**

October 2017

### **The complaint**

Mrs S complained that the Trust did not appropriately diagnose or treat her daughter's infections or recognise that she had developed sepsis, and that she died as a result. She complained that the Trust did not communicate the sepsis diagnosis to the family.

She also complained that the Trust didn't investigate her daughter's case until after she had complained, and that the investigation was unsatisfactory, which meant they could not prevent the same mistakes happening to others.

### **Background**

In October 2015 Miss S was taken by ambulance to the Emergency Department (ED) of the Trust and then transferred to the Acute Medical Unit (AMU) where she was treated for a chest infection and sepsis. Shortly before this, her GP had treated her for a urinary tract infection (UTI) and a chest infection.

On admission to the AMU, Miss S's respiratory rate and oxygen saturation were within the normal range. Her initial assessment and the ambulance record, documented pain coming from her abdomen, but no further action was taken. A chest X-ray showed that part of her lung had filled with fluid instead of air which can indicate a lung infection.

Mrs S told the Trust that her daughter had recently had UTIs and had received treatment from her GP. A urine dipstick was taken but the results were not recorded or reported to anyone. The Trust reviewed a urine sample taken by Miss S's GP days before her admission and the results supported the view that the urine infection could be the source of sepsis. Intravenous Co-amoxiclav, a broad spectrum antibiotic, was prescribed to primarily treat the chest infection.

An hour after admission, blood tests showed that the level of lactic acid in Miss S's blood was too high. Her urine output was measured and fluids were given, however a blockage prevented them from being given correctly. Recording the fluids given and passed was not started until Miss S was in the AMU and her lactic acid levels were not checked again to see if the treatment had corrected them.

The Trust gave Miss S another antibiotic, Gentamicin, to treat the UTI at 1.30pm, which was 15 hours after her admission. While waiting to have a CT scan, Miss S suffered a cardiac arrest at 2.10pm and sadly died at 3.48pm on 30 October 2015.

Mrs S complained to the Trust about the care that her daughter had received and the Trust undertook a serious incident investigation.

### **What we found**

We partly upheld this complaint. We found significant failings in the care of Miss S provided by the Trust. She had clear signs of a UTI which were not appropriately responded to. The antibiotics given to treat the chest infection were assumed to be adequate to also treat the UTI. However, bacteria found in the urine were resistant to the antibiotic given and therefore it was not effective. The more appropriate antibiotic was not prescribed until over 15 hours after Miss S's admission.

When Miss S complained of abdominal pain, good practice should have been to carry out an ultrasound of the abdomen which would likely have shown further evidence of the UTI. This would have allowed the correct treatment to be initiated at the earliest opportunity.

The nursing staff in both the ED and AMU missed opportunities to monitor and manage Miss S's fluid input and output and lactate level, and results of a urine dipstick were not recorded or reported to anyone. If the appropriate antibiotics and fluids had been started earlier, the sepsis could have been treated.

We found that the Trust's investigation did not cover all of the issues that were identified, or acknowledge that if it had provided the right care and treatment then Miss S's death would have likely been avoided, causing Mrs S significant distress.

### **Putting it right**

We recommended that the Trust write to Mrs S to acknowledge and apologise for the failings in her daughter's care and treatment.