SPSO decision report

Case: **201101249, Tayside NHS Board**
Sector: health
Subject: clinical treatment; diagnosis
Outcome: not upheld, no recommendations

Summary

Mrs C's mother (Mrs A) fell at home and was taken to A&E at Ninewells Hospital. X-rays confirmed that Mrs A had broken her femur and she was transferred to a ward a few hours later. The plan was for Mrs A to have surgery the next morning so she was given no food. When Mrs C called the ward the following morning she was told that there had been an emergency and Mrs A had not yet gone to theatre.

Mrs A went to theatre for her operation that evening. Mrs C telephoned the ward the next morning and was told that her mother had had a satisfactory night and was fine apart from being 'a bit chesty'. When Mrs C and her daughter arrived that afternoon they were told that Mrs A's condition had deteriorated and a team were attempting to resuscitate her. The attempt was unsuccessful and Mrs A died.

When her family saw her, they believed that she had been dead for some time given her pallor and temperature. Mrs C also complained that Mrs A was not given something to eat when she was transferred to the ward and that there had been an unreasonable delay in getting her to theatre. Furthermore, Mrs C believed that no appropriate action had been taken to address her mother's condition following surgery and that it was inappropriate that the family were not alerted when her condition deteriorated. Finally, Mrs C complained about the delay by the board in responding to her complaint.

The board accepted that Mrs A should have been given something to eat when she was transferred to the ward and apologised for their failure to do so. They also acknowledged that there was an unreasonable delay in responding to the complaint and apologised.

In regards to the timing of the operation, we found that this was reasonable as Mrs A's operation began just over 24 hours after admission. We also found that

Mrs A's deterioration was rapid and that the care and treatment she received following her operation was reasonable and timely and that the board's failure to alert the family was reasonable in the circumstances. Finally, we found that there was no evidence to bring the timing of Mrs A's death as recorded by the board into question.