SPSO decision report

Case: 201508908, Greater Glasgow and Clyde NHS Board - Acute Services Division
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

[When this report was first published on 19 October 2016, the Southern General Hospital was incorrectly named as the hospital being complained about. This should have said Victoria Infirmary. This was due to an administrative error for which we apologise.]

Mrs C complained about the care and treatment her late mother (Mrs A) received at the Southern General Hospital. Mrs A died following an endoscopy (a medical procedure where a tube-like instrument is put into the body to look inside). During the procedure biopsies (tissue samples) were taken, which later led to a bleed.

Following Mrs A's death, the Crown Office and Procurator Fiscal (COPFS) investigated and concluded that they would not refer the death to a Fatal Accident Inquiry.

Mrs C complained to the board at this point, saying she was advised to do this once the COPFS had finished their investigation. The NHS complaints procedure places a 12-month time-limit for considering complaints. The board said that as they had fully cooperated with the COPFS inquiry, there would be no further information to offer and they would not extend the timescale.

We used our discretion to investigate the complaint. We took independent advice from three clinical advisers. The nursing adviser noted that a SEWS (Scottish Early Warning System - a set of patient observations to assist in the early detection and treatment of serious cases and support staff in making clinical assessments) chart was missing. The gastroenterology adviser noted the recording on some of the drug charts was inadequate. The third adviser was a physician and while they noted these omissions in the medical notes, they did not find evidence that the care Mrs A received was unreasonable. While we noted some clinicians would not have biopsied Mrs A, considering her other health conditions, we found this was a degree of professional judgement and the decision to biopsy Mrs A was not unreasonable.

We did, however, uphold Mrs C's complaint about the board's response to her complaint to them and made recommendations to address the failings. We found that, given the serious nature of Mrs C's concerns and the fact that the board were not previously aware of the content of the COPFS report, it would have been good practice for the board to investigate Mrs C's concerns to identify potential learning and give her the opportunity to discuss her concerns. Additionally, the board have a duty to advise complainants that if they will not extend their timescales, the complainant has the right to come to SPSO. This did not happen in this case.

Recommendations

We recommended that the board:

- apologise to Mrs C for the fact that a SEWS sheet was missing from the clinical records;
- apologise to Mrs C for the fact that drug charts were incomplete and ensure all relevant staff are aware of the necessary record-keeping flowing from the guidelines on anti-coagulation in endoscopy;
- apologise to Mrs C for not advising her of her right to refer her complaint to the SPSO for consideration;
- share the learning from this complaint with relevant staff; and
- reflect on the impact on Mrs C of their refusal to consider investigating her complaint and advise us of the outcome of their reflection.